

SURVEY ITEM & SELF-ASSESSMENT						
SERVICE STANDARD 01 : GOVERNANCE, LEADERSHIP AND DIRECTION						
	<u>PREAMBLE</u> <i>Each Facility shall have a body ultimately responsible for all aspects of the Facility’s operations. This is commonly called the Board of Directors/Facility Management or other similar name. For the purposes of these Standards, this group shall be called “The Governing Body”. The Governing Body may delegate its duties and functions to the Person In Charge (PIC) of the Facility who shall be responsible for the organisation, management and control of the Healthcare Facility and services.</i> <i>For private healthcare facilities, a license or registration is required which relates to the services.</i> <i>For Public Hospital where Cluster Services is being provided; the services shall be reflected in the Lead and Non-Lead organization chart.</i>					
<u>TOPIC 1.1</u> STANDARD 1.1.1	<u>ORGANISATION AND MANAGEMENT</u> <i>The Governing Body shall adopt a governing framework that constitutes the internal legislation that will meet the particular needs and complexities of the management of the Facility and the range of services. These may be called Facility Operational Policies and Medical Staff By-Laws, which include Rules and Regulations, Terms of Reference, Policies, Resolutions or other similar terms and they shall govern the actions of the Board and Management of the Facility. The governing framework is essential for the governance of the Facility.</i>					
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
1.1.1.1	The Governing Body shall ensure that the Vision, Mission and values statements, goals and objectives are identified, clearly documented and measurable; these reflect the Facility’s roles and aspirations in the community that it serves. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.					
EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements, goals, and objectives of the Facility are available; endorsed and dated by the Governing Body.					
	2. Evidence of planned reviews of the above statements.					

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		3. These statements are communicated to all staff (orientation programme, minutes of meeting, etc).				
		4. Achievement of goals and objectives are monitored, reviewed, and revised accordingly.				
		5. Cluster Management Committee shall have their own vision and mission specifying their service areas/disciplines				
	Facility Comments:					
1.1.1.2	The Governing Body shall ensure that in defining the roles of the Facility, the needs of the community to be served are addressed and shall include policies and procedures on Patient and Family Rights with input from the Board of Visitors.					
	EVIDENCE OF COMPLIANCE	1. Board of Visitors				
		2. Policy on Patient and Family Rights				
		3. Patient's charter				
	Facility Comments:					
1.1.1.3 CORE	The Governing Body shall adopt a governing framework in accordance with statutory and other legal requirements.					
	EVIDENCE OF COMPLIANCE	1. License to operate (Private Healthcare Facility)/Gazettement letters and supporting documents (Public Healthcare Facility)				
		2. Appointment of full time Person In Charge (PIC) in accordance with the Third Schedule in Private Healthcare Facilities and Services Act 1998 and Regulations 2006.				
		3. Facility Operational Policies				
		4. Medical Staff By-Laws or equivalent				
		5. Medical Staff By-Laws or equivalent to address the disciplines under Cluster Services (where applicable)				
	Facility Comments:					

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1.1.1.4 CORE	The governing framework shall include the following elements, unless otherwise provided for by statute:			
	a) the Facility shall have a plan of organisation which includes an organisation chart that:			
	i) provides a clear representation of the structure, functions and reporting relationships of the services;			
	ii) is accessible to all staff;			
	iii) is revised when there is a major change in organisation plan; functions; reporting relationships; goals and objectives and staffing patterns.			
	iv) shall be exhibited in a conspicuous part of the Facility.			
	b) appointment of members of the Governing Body, its officers including Person In Charge (PIC), and committees; any qualifications required of the incumbents, and the terms of office; shall be done according to the relevant Acts, Regulations and By-Laws. Authority and duties of the Governing Body, its officers and committees are documented.			
	c) shall indicate relationship of the Governing Body, Person In Charge, other executive staff and show the structure of reporting relationship of the services, medical practitioners, nursing and all other allied healthcare professionals.			
	d) review of the governing framework at regular intervals and the governing framework is accessible to staff of the Facility.			
EVIDENCE OF COMPLIANCE	1. Current organisation chart of the Facility endorsed by the Governing Body which comply with (a)(i) to (iv).			
	2. Appointment letters of members of the Governing Body, its officers, and committees			
	3. Job descriptions			
	4. Terms of Office/Tenure of officers			
	5. Terms of Reference of committees			
	6. Minutes of Facility-wide Management Committee meetings			
	7. Minutes of Board meetings			
	8. Evidence of review of the following documents (at least once every three years or earlier if needed)			

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		a) Facility-wide Operational Policies							
		b) Departmental/Service Operational Policies							
		c) Medical Staff By-Laws							
		d) Terms of Reference of committees							
		e) Cluster Service to be reflected in the organisation structure (where applicable)							
		f) Above documents are made accessible to all staff.(hard or soft copies)							
	Facility Comments:								
1.1.1.5	The Governing Body shall make provision for the establishment and delineation of the purpose and function of any auxiliary organisations, such as St. John's Ambulance, Red Crescent, Angkatan Pertahanan Awam (APM) and others.								
	EVIDENCE OF COMPLIANCE	1. Memorandum of Understanding and Terms of Reference with voluntary/auxiliary organisations.							
	Facility Comments:								

SURVEY ITEM & SELF-ASSESSMENT															
STANDARD 1.1.2	<i>There shall be an appointment of the Person In Charge (PIC) who shall be a person possessing such qualification, training and experience as prescribed according to the relevant Acts, Regulations and By-Laws. The Person In Charge (PIC) shall be responsible for the organisation, management and control of the Healthcare Facility or services to which a license or registration relates and shall answer to the Governing Body. Clinical staff appointments, credentialing and privileging shall be documented. These shall meet the requirements of the relevant Acts, Regulations and By-Laws.</i> <i>There shall be a Medical and Dental Advisory Committee to advise the Governing Body to plan, coordinate, implement, control and improve activities relating to clinical patient care.</i>														
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS												
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING											
1.1.2.1	The appointment of the Person In Charge (PIC) shall be done according to the relevant Acts, Regulations and By-Laws. He/She shall ensure that specialised departments, services, their heads and their staff also meet the requirements of the relevant Acts, Regulations and By-Laws. The authority delegated to the Person In Charge (PIC) or other persons; and the right of the Governing Body to rescind such delegation is reflected in the governing framework. <table><tr><td rowspan="2">EVIDENCE OF COMPLIANCE</td><td>1. Appointment letter of PIC/Hospital Director</td><td></td></tr><tr><td>2. Job description of PIC/Hospital Director</td><td></td></tr><tr><td colspan="3">Facility Comments:</td></tr><tr><td colspan="3"></td></tr></table>	EVIDENCE OF COMPLIANCE	1. Appointment letter of PIC/Hospital Director		2. Job description of PIC/Hospital Director		Facility Comments:								
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Facility Comments:															
1.1.2.2	The Person In Charge (PIC) shall hold a degree in medicine, registered with Malaysian Medical Council and has appropriate training and experience in accordance with the Third Schedule in the Private Healthcare Facilities and Services Act 1998 and Regulations 2006. <table><tr><td rowspan="2">EVIDENCE OF COMPLIANCE</td><td>1. Resume of PIC/Hospital Director</td><td></td></tr><tr><td>2. Letter of appointment</td><td></td></tr></table>	EVIDENCE OF COMPLIANCE	1. Resume of PIC/Hospital Director		2. Letter of appointment										
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	Facility Comments:				
1.1.2.3	The authority, responsibilities and accountabilities of the Person In Charge (PIC) are clearly delineated and documented in a letter of appointment.				
	EVIDENCE OF COMPLIANCE	1. Letter of appointment of PIC/Hospital Director by the Chairman of the Governing body (BOM or BOD)			
		2. Job description			
	Facility Comments:				
1.1.2.4	The Person In Charge (PIC) shall be responsible to establish an organisational structure that clearly represents the uniformity of the clinical services and reporting relationships. Where there are two or more registered medical practitioners/dental practitioners in any one specialty in the Facility, separate designated heads and functional units/services to be established for effective delivery of clinical services.				
	EVIDENCE OF COMPLIANCE	1. The Facility's organisation chart showing the uniformity and reporting relationships of the clinical services.			
		2. Organisation charts of clinical services by departments/functional units with clear evidence of line of reporting.			
		3. Agenda and minutes of meetings of department/functional units shall be approved by the HOD.			
	Facility Comments:				
1.1.2.5	The Governing Body through the Person In Charge shall establish the following policies and procedures for medical practitioners: a) appointment; b) reappointment; c) delineation of clinical privileges, roles and responsibilities.				

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	EVIDENCE OF COMPLIANCE	1. Policies and procedures on: a) Credentialing and privileging b) Appointment and reappointment 2. Minutes of Credentialing and Privileging Committee 3. Certified privileging certificates (with serial number) 4. Roles and responsibilities for medical practitioners/consultants				
	Facility Comments:					
1.1.2.6 CORE	The licensee of the Facility shall establish a Medical and Dental Advisory Committee (MDAC) whose members shall be registered medical and dental practitioners representing all medical and dental practitioners practising in the Facility and shall advise the Governing Body and Person In Charge (PIC) on all aspects relating to medical and dental practices. In the smaller public facilities, the Medical Staff/Clinical Staff Committee functions as the MDAC. The MDAC is expected to discharge its duties and responsibilities through subcommittees.					
	EVIDENCE OF COMPLIANCE	1. Establishment of MDAC/MAC 2. Appointment letter of members of MDAC/MAC 3. Terms of Reference of MDAC/MAC 4. Minutes of meetings				
	Facility Comments:					
1.1.2.7	The MDAC and/or its subcommittees shall address at least the following areas of concern: a) development and consensus of policies, procedures and standards of patient care evidence based guidelines; b) credentialing and privileging of clinical care providers; c) maintenance of professional standards and ethics; d) safety and performance improvement activities and risk management framework which shall include both reactive and proactive measure; e) clinical documentation and medical records;					

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	f) prevention and control of infection and antibiotic usage; g) drug utilisation and medication practices; h) use of blood and blood products; i) continuing professional development, training and continuing medical education; j) facilitation and supervision of research including the ethical aspects of research where appropriate.					
	EVIDENCE OF COMPLIANCE				1. List of standing agenda (if no subcommittees) / subcommittees to address (a) to (j)	
					2. Membership of subcommittees (if applicable 2 - 5)	
					3. Appointment letter of members of subcommittees	
					4. Terms of Reference of subcommittees	
					5. Minutes of meetings of subcommittees	
	Facility Comments:					
1.1.2.8	The Management Committee or its equivalent shall meet with sufficient regularity and with an adequate quorum. Minutes shall be kept and accessible to members. Findings, decisions and resolutions made during meetings shall be communicated to relevant staff members of the Facility and to the Governing Body.					
EVIDENCE OF COMPLIANCE	1. List of members of Management Committee and subcommittees					
	2. Evidence that Management Committee members represent the various respective departments					
	3. Letter of appointment					
	4. Terms of Reference					
	5. Minutes of meetings of Management Committee and subcommittees (where applicable)					
Facility Comments:						

SURVEY ITEM & SELF-ASSESSMENT									
STANDARD 1.1.3		Service planning is based on the organisation's strategic direction and due consideration of financial factors and the external environment. The financial management of the Facility shall be organised to allow reasonable financial reports to be generated.							
		CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS			
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1.1.3.1	The Governing Body through the Person In Charge (PIC) and Management Team is responsible for the efficient management of the financial resources of the Facility.								
	EVIDENCE OF COMPLIANCE	1. Financial management reflected in job descriptions of PIC and Management Team (Heads of Services)							
		2. Designated Finance/Account Officer							
		3. Minutes of financial and management meeting							
		4. Financial management report							
		5. Auditor's report (internal and external)							
		6. Annual budget report							
	Facility Comments:								
1.1.3.2	An external audit is carried out by an appropriately qualified independent auditor at least on an annual basis and is reported to the Governing Body or its representative.								
	EVIDENCE OF COMPLIANCE	1. Credentials of the external auditor							
		2. External auditor's report							
	Facility Comments:								
1.1.3.3	The Governing Body or its representative (Board of Management) regularly reviews audit reports; and action is taken on any recommendations made by the auditor.								
	EVIDENCE OF COMPLIANCE	1. Financial management reports							
		2. Minutes of Governing Body or Board of Management							
		3. Actions taken on auditor's recommendations.							
	Facility Comments:								

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1.1.3.4	There is an appropriate programme of internal financial control.					
	EVIDENCE OF COMPLIANCE	1. Financial Standard Operating Procedures or Treasury Instruction/Circular				
		2. System for internal financial control				
	Facility Comments:					
1.1.3.5	An internal accounting system, which produces information reflecting the fiscal experience and the current financial position of the Facility, is maintained.					
	EVIDENCE OF COMPLIANCE	1. Internal accounting system				
		2. Current financial report				
	Facility Comments:					
1.1.3.6	There are written policies and procedures for all accounting functions.					
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for all accounting functions.				
		Facility Comments:				
1.1.3.7	There is an appropriate and effective system of inventory and stock control.					
	EVIDENCE OF COMPLIANCE	1. System for inventory :				
		a) Stock taking				
		b) Registry of inventory				
		c) Stock cards				
		2. Receipt and distribution of assets				
		3. Disposal of assets				
Facility Comments:						

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1.1.3.8	A budget is developed with the participation of appropriate staff. Periodic reports showing the relationship between the budget and actual expenditure shall be produced and analysed.						
	EVIDENCE OF COMPLIANCE	1. Mechanism for budget preparation					
		2. Budget Proposals					
		3. Capital expenditure (CAPEX) or Operational expenditure (OPEX)					
		4. Budget monitoring report (Analysis on budget versus expenditure)					
	Facility Comments:						
1.1.3.9	There is provision of comprehensive financial management reports to the Governing Body and periodic review as to the accuracy and appropriateness of these reports.						
	EVIDENCE OF COMPLIANCE	1. Financial report to Board of Management/Board of Directors (Private Healthcare Facility)					
		2. Financial report to Management (Public Healthcare Facility)					
		3. Internal and external auditor's reports					
	Facility Comments:						
1.1.3.10	There is an insurance programme for: a) the protection of the buildings, contents, and other physical assets; b) the protection of the financial assets; c) professional liability to protect the Facility in respect of the professional actions of medical practitioners, paramedics and other support services staff.						
	EVIDENCE OF COMPLIANCE	1. Insurance policy certificate with details on covers for (a) to (c).					
	Facility Comments:						

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1.1.3.11	The Governing Body shall establish an integrated information and communication strategy, structure and system that include the following: a) Organisational structure clearly shows line communication, interaction and decision making. b) Policies and procedures clearly allow data and information gathering and knowledge sharing within department, inter departmental and whole facility as well as with outside organization (where relevant)				
	EVIDENCE OF COMPLIANCE	1. Organisational chart especially showing clear clinical line of communication, interaction and decision making			
		2. Clinical policies and procedures			
		3. Patients records management system including completeness and quality of content of medical record			
		4. Information and communication technologies and tools example : PABX, Pagers, Phones, Social Media, etc.			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT						
STANDARD <u>1.1.4</u>	<i>The Governing Body shall ensure that all reasonable action is taken to conform to all applicable government Statutes, Acts, Regulations, By-Laws, Ordinances and Orders; and shall treat all information relating to the affairs of the Facility, patients and staff in a confidential manner.</i>					
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
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1.1.4.1	The Governing Body shall ensure that all reasonable action is taken to conform to all applicable government Statutes, Acts, Regulations, By-Laws, Ordinances and Orders.					
	EVIDENCE OF COMPLIANCE	1. Copies of all relevant Acts, Regulations, By-Laws, Ordinances and Orders related to the services are available and accessible to staff.				
		2. Certificate of fitness of buildings, facilities and other physical assets.				
		3. Reprimands/summons from Health Authorities and Fire Authority where applicable.				
		4. Incident reporting related to non-conformance to relevant Acts and Regulations if any.				
	Facility Comments:					
1.1.4.2	The Governing Body and staff shall treat all information relating to the affairs of the Facility, patients and staff in a confidential manner.					
	EVIDENCE OF COMPLIANCE	1. Policy on disclosure of information relating to the affairs of the Facility.				
		2. Policy statements regarding release of patient information.				
		3. Documented evidence of undertaking on confidentiality by staff.				
		4. Compliance with Personal Data Protection Act (PDPA), Medical Records Guidelines from Ministry of Health and Malaysian Medical Council.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT				
STANDARD 1.1.5	Where external services are used to assist in the operations of the Facility, these contracted or referral services shall meet the MSQH Standards of Accreditation.			
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1.1.5.1 CORE	There are written agreements on the appointment and provision of external services to the Facility, which include the following: a) The services shall meet all patient and environmental safety standards contained in the MSQH Standards of Accreditation, regardless of where the activities occur, on-site and off-site. b) There is documentation on the external aspects of the services which refer to: i) specification of formal lines of communication and responsibility between the external source provider and the Facility; ii) provision of services by personnel appropriately qualified to perform their duties; iii) adequate pick-up and delivery arrangements; iv) appropriate participation of the external service provider in committees of the Facility where applicable; v) arrangements for after-hours and emergency services; vi) quality control of the external services including involvement in safety and performance improvement activities of the Facility, as appropriate; vii) procedures for identifying and rectifying problems in the delivery of the services; viii) adequacy of facilities and equipment for the services being provided at both the Facility and the site of the external services; ix) personnel provided by the external services who shall be bound by the rules and regulations applicable to the staff of the Facility.			
	EVIDENCE OF COMPLIANCE 1. Service contracts have appropriate terms and conditions as in (a) and (b) including: a) date and duration of contract; b) system for quality control of outsourced services (visit to off-site services, recognised certification);			

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		c) procedures for managing shortfall in service;					
		d) Involvement in performance measurement of the relevant services provided to the Healthcare Facility.					
	Facility Comments:						

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 1.2:		<u>HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT</u>				
STANDARD <u>1.2.1</u>		<i>The Governing Body shall make adequate provision for the delegation of authority to the Person In Charge to ensure the achievement of the Facility's Vision, Mission, values, goals and objectives.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
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1.2.1.1	The Person In Charge (PIC) acts in accordance with the policies, delegated authority, and instructions of the Governing Body; and is responsible for the organisation, management and control of the Facility.					
	EVIDENCE OF COMPLIANCE	1. Authorisation of all policies within the Facility				
		2. Chairing of Credentialing and Privileging Committee				
		3. Establish Continuing Medical Education (CME) Committee				
		4. Establish/conduct Professional and Disciplinary Committee meetings				
		5. Notes: For Cluster Services:				
		a) Chairing of Credentialing and privileging by Cluster				
		b) Establish CME by Cluster Committee				
		d) Conferment of Privileging Rights to be done by relevant authorities, CMC and PIC				
	Facility Comments:					
1.2.1.2	The Person In Charge (PIC) shall attend all meetings of the Governing Body.					
	EVIDENCE OF COMPLIANCE	1. Attendance of PIC in minutes of meetings of Governing Body.				
Facility Comments:						

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1.2.1.3	The performance of the Person In Charge (PIC) shall be regularly reviewed by the Governing Body.					
	EVIDENCE OF COMPLIANCE	1. Documented performance appraisal of PIC by the Board of Management				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
STANDARD 1.2.2	APPOINTMENT, VERIFICATION OF CREDENTIALS AND PRIVILEGING <i>The appointment, reappointment and clinical privileges of medical practitioners, nursing and other healthcare professionals to the Healthcare Facility are appropriate to the complexity of services of the Facility.</i>					
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
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1.2.2.1 CORE	The appointments of staff are made by the Governing Body or any delegated authority. For the medical practitioners, the Governing Body shall seek the advice of the Credentialing and Privileging Committee. The membership of the Credentialing and Privileging Committee may include representatives of the Governing Body and regional representation of medical practitioners. The committee meets regularly to make recommendations on the appointment, reappointment, and clinical privileges of each member of the staff of the facilities.				☐	
	EVIDENCE OF COMPLIANCE	1. Appointment and reappointment policy according to services listed in the hospital license				
		2. Credentialing and privileging policies				
		3. Minutes of meeting of Credentialing and Privileging Committee				
		4. Evidence of compliance to procedure privileged to do against areas eg OT list for the said medical practitioner.				
	Facility Comments:					
1.2.2.2	There are written and dated specific job descriptions for all categories of staff that include: a) qualifications, training, experience and certification required for the position; b) lines of authority; c) accountability, functions and responsibilities; d) reviewed when required and when there is a major change in: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities;					

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	iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations.						
EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (d).						
	2. Job description includes specialisation skills						
	3. Relevant privileges granted where applicable						
	4. The job description is acknowledged by the staff and signed by the Head of Service and dated.						
Facility Comments:							
1.2.2.3 CORE	The criteria and mechanism taken by the Facility in determining appointments and privileges shall adhere to the following: a) the written policies and procedures for Appointment, Credentialing and Privileging; b) the decisions made are objective, fair and impartial; c) reappointments and privileges shall each be granted for a specified period of time; d) when appropriate, temporary appointments and privileges may be granted for a limited period of time according to a policy approved by the Governing Body; e) appointments and privileges are allocated in such a way that each staff functions within a specified area of competence.						
EVIDENCE OF COMPLIANCE	1. Written policies and procedures for Appointment, Credentialing and Privileging.						
	2. Credentialing and privileging criteria include items (b) to (e)						
Facility Comments:							
1.2.2.4 CORE	Criteria for determining appointments and privileges are specified and uniformly applied to all applicants based on the following principles: a) the criteria are designed to ensure patients will receive safe and quality care;						

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	b) the criteria include evidence of current competence, relevant training and/or experience, and current registration with the local professional registration bodies, e.g. Malaysian Medical Council; other criteria may apply, e.g. the needs of the Facility;			
	c) personal recommendations are taken into account when recommendations for individual appointments and privileges are being considered;			
	d) the relevant department and/or major professional services shall be represented when recommendations for individual appointments and privileges are being considered.			
EVIDENCE OF COMPLIANCE	1. Minutes of meetings of Credentialing and Privileging Committee			
	2. Criteria for privileging rights to include items (b) and (c).			
	3. Recommendations from referee			
	4. Presence of relevant Head of Service at award of privileging rights to the individual at Credentialing and Privileging Committee meeting.			
Facility Comments:				
1.2.2.5	The process for determining appointments and granting clinical privileges shall include the following: a) the applicant's request; b) the verification of qualifications submitted by applicants; c) the verification that relevant staff members are registered with the relevant national registers (Malaysian Medical Council and other registers for example, Nursing Board Malaysia, Medical Assistants Board Malaysia etc.); d) where relevant the staff member has a valid annual practising certificate; e) the staff member is professionally qualified for the position held; f) the assignment of duties and privileges that matches the qualifications and experience thus ensuring that he/she is capable of carrying out the duties and privileges to be accorded; g) the resources available in the Facility support the duties and privileges.			

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	EVIDENCE OF COMPLIANCE	1. The process of granting clinical privileges shall include items (a) to (g).			
	Facility Comments:				
1.2.2.6	The Governing Body shall formally grant in writing the delineated clinical privileges to each member appointed based on the recommendations of the Credentialing and Privileging Committee.				
	EVIDENCE OF COMPLIANCE	1. Certified privileging certificates			
	Facility Comments:				
1.2.2.7					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	EVIDENCE OF COMPLIANCE	1. The reappointment and renewal of clinical privileges shall consider items (a) to (e).					
		2. Provision of upgrading and downgrading of privileges.					
	Facility Comments:						
1.2.2.8	There is an avenue for appeals when decisions on clinical privileges and appointments are adverse to the applicant. This mechanism provides for review of decisions when requested by the applicant. The final decision in all cases shall be taken by the Governing Body and within a fixed period of time.						
	EVIDENCE OF COMPLIANCE	1. Appeal Policy on clinical privileges is available.					
	Facility Comments:						

SURVEY ITEM & SELF-ASSESSMENT								
STANDARD 1.2.3		The Person In Charge (PIC) shall ensure effective human resource management system is in place in order for the Facility to operate efficiently.						
		CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
1.2.3.1 CORE		The Person In Charge (PIC) shall ensure that an adequate number of appropriately qualified staff are available to meet the needs of patient care.						
		EVIDENCE OF COMPLIANCE	1. Staff master plan					
			2. Staff patient ratio appropriate to level of care					
			3. Duty roster					
			4. Job description					
			5. Policy and procedures on qualification verification					
		Facility Comments:						
1.2.3.2		The Person In Charge (PIC) shall establish and maintain policies and practices for staff planning that support safe patient care. These policies are: a) written and available to all employees; b) reviewed periodically at least once in three years and revised as necessary with the date of the most recent review being incorporated; c) established to include a procedure for notifying employees of changes in the policies.						
		EVIDENCE OF COMPLIANCE	1. Human Resource policies					
			2. Employee Handbook					
			3. Policies are updated, endorsed and dated.					
			4. Changes in policies are notified to the staff.					
		Facility Comments:						

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
1.2.3.3	The Person In Charge (PIC) shall maintain accurate, complete and confidential staff records. These shall include the following but not limited to: a) records on leave and sickness with documented evidence; b) results of recent staff appraisal; c) qualifications held; d) evidence of current registration; e) records on clinical placements; f) amendments to the employment contract; g) records on continuing education and training; h) records on staff counselling sessions; i) records on disciplinary action.					
	EVIDENCE OF COMPLIANCE	1. Staff personal records which include but not limited to items (a) to (i).				
		2. Staff personal records are kept confidential				
	Facility Comments:					
1.2.3.4	Staff receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.					
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff is completed upon probationary period and as an annual exercise. Notes: The Cluster Service PIC are involved in their performance appraisal which will be based on letter of appointment and specifications of their roles and responsibilities namely Clinical Governance, staff training and competence assessment and provide service where applicable.				
		Facility Comments:				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
1.2.3.5	There is evidence that staff are involved in the appraisal of their performance.					
	EVIDENCE OF COMPLIANCE	1. Evidence of staff involvement in the appraisal of their performance. Notes: The Cluster Service PIC are involved in their performance appraisal which will be based on letter of appointment and specifications of their roles and responsibilities namely Clinical Governance, staff training and competence assessment and provide service where applicable.				
	Facility Comments:					
1.2.3.6 CORE	Avenues for processing and reporting suggestions and grievance are clearly described and made known to the staff.					
	EVIDENCE OF COMPLIANCE	1. Staff satisfaction survey, suggestions and grievance reporting, and processing mechanisms are available.				
		2. Evidence of actions taken				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT					
STANDARD 1.2.4	<i>The Governing Body through the Person In Charge (PIC) shall ensure that staff follow the professional ethics of their respective professional bodies.</i>				
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
1.2.4.1	The Person In Charge (PIC) shall put in place a mechanism for the consideration of ethical issues faced by the Facility and for implementation of the resulting policies in timely manner.				
	EVIDENCE OF COMPLIANCE	1. Policies on ethical issues.			
		2. Ethics Committee or any other committees where ethical issue is discussed.			
		3. Minutes of meetings			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT							
STANDARD 1.2.5		The Governing Body through the Person In Charge (PIC) shall ensure that there are continuing education, orientation and in-service programmes for its members and all the staff in order to improve their knowledge and skills, thereby improving the function of the individual service.					
		CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
1.2.5.1	There is a planned orientation programme for newly appointed members of the Governing Body and Board of Visitors.						
	EVIDENCE OF COMPLIANCE	1. Orientation programme for Governing Body and Board of Visitors					
		2. Orientation module					
		3. Attendance list					
	Facility Comments:						
1.2.5.2	There is a planned orientation programme for all categories of newly appointed staff including medical practitioners. This programme is appropriate to the size of the Facility and includes: a) information on the Vision, Mission and values statements, Goals and Objectives of the Facility; b) explanation of particular duties and functions, lines of authority, areas of responsibility, and methods of obtaining appropriate resource materials; c) explanation of the expected responses to internal events, e.g. fire safety and external disasters and other contingencies; d) information about safety procedures including universal/standard precautions; e) provision for the acquisition of necessary additional skills; f) explanation of the methods that will be used to evaluate staff performance.						
	EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme.					
		2. There is orientation programme with relevant topics not limited to topics covered from (a) to (f) and supported by an individual area/unit specific orientation checklist/programme.					
		3. Attendance list					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	Facility Comments:					
1.2.5.3 CORE	There is a planned staff development programme which provides in-service and continuing education opportunities for all categories of staff. The Person In Charge (PIC) whenever possible makes resources available to allow implementation of such programmes (This may be done in collaboration with other organisations).					
	EVIDENCE OF COMPLIANCE	1. A facility-wide staff development plan is available, dated and reviewed based on training needs assessment.				
		2. Minutes of Training Committee				
		3. Training calendar				
		4. Contents of training programmes shall include patient centric topics and business continuity plan				
		5. Training records on continuing education activities are kept and maintained for each staff.				
		6. Allocation of training budget				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT															
STANDARD 1.2.6	Where the Facility has teaching responsibilities to provide for the educational needs of medical undergraduates, postgraduates, nurses, allied health and other health professionals, there is a formal written agreement stating the terms of reference and the requirements of the teaching needs.														
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS												
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING											
1.2.6.1 CORE	There are written agreements which include the following: a) lines of communication; b) provision of appropriately qualified staff to provide clinical supervision; c) student activities should be fully supervised; d) the faculty staff participating in the teaching/training and patient care of all categories of students in the Facility are credentialed and privileged; e) mechanism for dealing with problems during the teaching/training period; f) meeting the appropriate Standards of Accreditation for that part of the teaching/training functions and patient care within the Facility; g) Indemnity.														
	<table border="1"> <tr> <td rowspan="5">EVIDENCE OF COMPLIANCE</td> <td>1. Memorandum of agreement to include items (a) to (g)</td> <td></td> </tr> <tr> <td>2. Joint management committee</td> <td></td> </tr> <tr> <td>3. Minutes of meetings</td> <td></td> </tr> <tr> <td>4. Contracts where applicable (private institutions)</td> <td></td> </tr> <tr> <td>5. Compliance with the Memorandum of Agreement/contract.</td> <td></td> </tr> </table>	EVIDENCE OF COMPLIANCE	1. Memorandum of agreement to include items (a) to (g)		2. Joint management committee		3. Minutes of meetings		4. Contracts where applicable (private institutions)		5. Compliance with the Memorandum of Agreement/contract.				
EVIDENCE OF COMPLIANCE	1. Memorandum of agreement to include items (a) to (g)														
	2. Joint management committee														
	3. Minutes of meetings														
	4. Contracts where applicable (private institutions)														
	5. Compliance with the Memorandum of Agreement/contract.														
	Facility Comments:														

1.2.6.2	Organisations should have arrangements for the: a) promotion of staff well-being b) resolution of workplace issues				
	EVIDENCE OF COMPLIANCE	1. The promotion of staff well-being may involve:			
		a) procedures to promote well-being, e.g. stress management, workload monitoring, management of worklife balance, healthy lifestyle programmes eg. BookDoc, KOSPEN			
		b) staff being provided with appropriate supervision, support and advice e.g. Mentor Mentee			
		2. The resolution of workplace issues may involve:			
		a) measures to protect staff against violence, bullying and harassment e.g. signage			
		b) clear procedures for the effective management of underperformance eg feedback on Sasaran Kerja Tahunan (SKT)			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 1.3:	<u>POLICIES AND PROCEDURES</u>					
STANDARD 1.3.1	<i>The Governing Body through the Person In Charge (PIC) shall ensure that documented and dated policies and procedures in line with the requirements of the relevant regulations are available to guide all staff, including medical practitioners and locums, patients and visitors in respect of the operations of the Facility.</i>					
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
1.3.1.1 CORE	In determining policies and procedures, the Person In Charge (PIC) shall consider both external and internal factors relevant to the Facility and shall ensure that policies are: a) clearly articulated in understandable language; b) recorded in policy manuals; c) determined only on the basis of adequate information and consultation; d) able to guide those making decisions; e) capable of being implemented; f) relevant with current Acts, Regulations and By-Laws.					
	EVIDENCE OF COMPLIANCE				1. Facility-wide Operational Policies	
					2. Medical Staff By-Laws	
					3. Departmental policies and procedures	
					4. Policies are relevant with current Acts, Regulations and By-Laws.	
	Notes: The Cluster Service Policy shall be based on integrated care delivery where the patient care flow is ensured to be continuous and seamless throughout the patient care process from the non-lead to lead and vice versa.					
Facility Comments:						
1.3.1.2	The Person In Charge (PIC) shall ensure that the activities of the Facility are monitored and consistent with written policies.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Results of audits				
		2. Reports on supervisory visits (24 hours nursing report)				
		3. 24 hours Facility reports (Maintenance Department's report)				
	Facility Comments:					
1.3.1.3 CORE	Policies and procedures are dated, authorised, signed and reviewed at least once every three years and revised as required and readily accessible for reference.					
	EVIDENCE OF COMPLIANCE	1. Policies and procedures are updated, endorsed and dated.				
		2. Evidence of periodic review				
	Facility Comments:					
1.3.1.4 CORE	Policies and procedures are widely communicated throughout the Facility.					
	EVIDENCE OF COMPLIANCE	1. Circular or memos on new policies				
		2. Training and briefing on the current policies and procedures/Minutes of meetings				
		3. Circulation list and acknowledgement				
		4. Audits on staff compliance				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT				
TOPIC 1.4:	<u>FACILITIES AND EQUIPMENT</u>			
STANDARD 1.4.1	<i>The Governing Body through the Person In Charge (PIC) has the overall responsibility for ensuring the provision of appropriate facilities and equipment so as to enable the achievement of the objectives of the Facility, in keeping with relevant Acts, Regulations and By-Laws.</i>			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT
				SURVEYOR RATING
1.4.1.1	The Person In Charge (PIC) ensures that facilities and equipment are adequate and safe for the level of services provided.			
	EVIDENCE OF COMPLIANCE	1. Adequate facilities and equipment at each patient care area for safe care.		
		2. Appropriate type of equipment to match the complexity of services.		
		3. Planned replacement of equipment based on life cycle reports.		
		4. Planned refurbishment of the Facility/new facilities		
		5. Provision for budget allocation		
		6. Establishment of Procurement Committee		
	Facility Comments:			
1.4.1.2 CORE	There is evidence that the Facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.			
	EVIDENCE OF COMPLIANCE	1. Planned Preventive Maintenance records, such as schedule, stickers, etc.		
		2. Planned Replacement Programme where applicable		
		3. Complaint records		
		4. Asset inventory		
	Facility Comments:			
1.4.1.3	There are planned upgrading and replacement programmes for facilities and equipment.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Master plans for upgrading and replacement for facilities and equipment.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT							
TOPIC 1.5:		<u>SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES</u>					
STANDARD 1.5.1		<i>The Governing Body through the Person In Charge (PIC) shall establish, implement and monitor Risk Management Programme with a systematic and effective safety and performance improvement plan throughout the Facility as required under the relevant Acts, Regulations and By-Laws.</i>					
		CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
1.5.1.1 CORE		The Risk Management Programme refers to planned and systematic safety and performance improvement activities that shall include but not limited to risk reduction activities such as Mortality and Morbidity Reviews, Incident Reporting and Grievance Mechanism.					
		EVIDENCE OF COMPLIANCE	1. Establishment of Risk Management Program to include both clinical/nonclinical				
			2. Implementation and monitoring of risk assessment activities: -				
			a) Risk Register;				
			b) Risk assessment reports;				
			c) Root Cause Analysis (RCA) report;				
			d) action plans;				
			e) remedial measures;				
			f) clinical audit including patient safety programmes (mortality and morbidity review, etc).				
		g) Sentinel Events shall be investigated with appropriate corrective and preventive actions and discussed by the governing body.					
Facility Comments:							

1.5.1.2	There are clearly assigned responsibilities for safety and performance improvement activities within the services.					
	EVIDENCE OF COMPLIANCE	1. Assigned officers				
		2. Letter of appointment/assignment				
	Facility Comments:					
1.5.1.3	The Risk Management System addresses World Health Organization (WHO) Global Patient Safety Initiatives and Malaysian Patient Safety Goals.					
	a) World Health Organization (WHO) Global Patient Safety Challenges and Patient Safety Solutions (Appendix 1.a)					
	b) Malaysian Patient Safety Goals (Appendix 1.b). The reporting system is through the “e-goals-patient safety” of the Ministry of Health, http://patientsafety.moh.gov.my/ as indicated in the Director General of Health, Malaysia’s circular (Ref: KKM/87/P3/10/8/0Jld 7(11).					
	EVIDENCE OF COMPLIANCE	1. Report on implementation of World Health Organization (WHO) Global Patient Safety Initiatives as indicated in the <i>Appendix 1.a: World Health Organization (WHO) Global Patient Safety Initiatives</i>				
		2. Report on implementation of Malaysian Patient Safety Goals as indicated in the <i>Appendix 1.b: Malaysian Patient Safety Goals 2.0 Guidelines</i>				
		3. WHO Global Surgery Initiative (GSI) implementation for non-lead hospitals providing Cluster Surgical Services where applicable.				
Facility Comments:						
1.5.1.4 CORE	There is tracking and trending of the following specific performance indicators for the service:					
	a) percentage of patients leaving hospital against medical advice relative to all patients hospitalised within a specified period.					

	b) percentage of incidents/accidents during hospitalisation of patients as percentage of all admitted patients. c) hospital wide patient satisfaction survey (six monthly basis) d) In addition, healthcare facilities are required to monitor any other two (2) indicators with tracking and trending analysis to support its goals and objectives.					
	EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored.				
		2. Records on tracking and trending analysis.				
		3. Remedial measures taken where appropriate.				
	Facility Comments:					
1.5.1.5 CORE	Feedback on results of safety and performance improvement activities are regularly communicated to the staff, relevant authority and governing body. Results of safety and performance improvement activities are utilised for improvement of the organisation and management of the Facility.					
	EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff.				
		2. Evidence of feedback via communication on results of performance improvement activities e.g through continuing education activities/meetings.				
		3. Minutes of service/unit/committee meetings/governance body				
		4. Results of safety and performance improvement activities are utilised for improvement of the organisation and management of the Facility.				
	Facility Comments:					
1.5.1.6	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.					
	EVIDENCE OF COMPLIANCE	1. Documentations on performance improvement activities and performance indicators.				
		2. Policy statement on anonymity on patients and providers involved in performance improvement activities.				

	Facility Comments:			
1.5.1.7 CORE	There are safety and performance improvement activities that address staff safety.			
EVIDENCE OF COMPLIANCE	1. Staff health screening and medical check-up records.			
	2. Identification of health risk factors, workload monitoring and stress management			
	3. Infectious diseases prevention programme/activities			
	4. Anti-smoking programme			
	5. Healthy lifestyle campaign			
	6. Staff training on:			
	a) sharps and needle stick injury management;			
	b) Occupational Safety and Health;			
	c) ergonomics;			
	d) biohazard waste disposal.			
	7. Post exposure management			
	8. Handling aggressive patients/visitors			
	9. Universal/standard precautions			
	Facility Comments:			
1.5.1.8	Facility performance data shall made publicly available			
EVIDENCE OF COMPLIANCE	1. In the facility Annual Report			
	2. In the facilities website or any other forms of publication			
	Facility Comments:			

Appendix 1.a: World Health Organization (WHO) Global Patient Safety Initiatives

No	World Health Organization (WHO) Global Patient Safety Challenges	Implementation Status
1	Identify patient correctly	☐ Yes ☐ No
2	Improve effective communication	☐ Yes ☐ No
3	Improve the safety of high-alert medications	☐ Yes ☐ No
4	Ensure correct-site, correct-procedure, correct-patient surgery	☐ Yes ☐ No
5	Reduce the risk of healthcare associated infections	☐ Yes ☐ No
6	Reduce the risk of patient harm resulting from fall	☐ Yes ☐ No

No	World Health Organization (WHO) Patient Safety Solutions	Implementation Status
1	Look-Alike, Sound-Alike Medication Names	☐ Yes ☐ No
2	Patient Identification	☐ Yes ☐ No
3	Communication During Patient Hand-Overs	☐ Yes ☐ No
4	Performance of Correct Procedure at Correct Body Site	☐ Yes ☐ No
5	Control of Concentrated Electrolyte Solutions	☐ Yes ☐ No
6	Assuring Medication Accuracy at Transitions in Care	☐ Yes ☐ No
7	Avoiding Catheter and Tubing Misconnections	☐ Yes ☐ No
8	Single Use of Injection Devices	☐ Yes ☐ No
9	Improved Hand Hygiene to Prevent Healthcare Associated Infections	☐ Yes ☐ No

Appendix 1.b: Malaysian Patient Safety Goals 2.0 Guidelines

Type of facility	Goal No	PI	Indicator	Target	Frequency of monitoring	Annual Performance												Total	Average
						J	F	M	A	M	J	J	A	S	O	N	D		
INFECTION PREVENTION AND CONTROL																			
Hosp	1	1	Hand Hygiene Compliance Rate	≥ 75%	6 Monthly														
Hosp		2	Rate of Catheter Associated Blood Stream Infection (CABSI) - No. of CABSI per 100 admissions	≤ 0.5 Per 100 Admissions	Once / Year														
SAFE SURGERY SAVES LIVES																			
Hosp with OT	2	3	Number of "Wrong Surgeries" performed	Zero (0)	Monthly														
Hosp with OT		4	Number of Unintended Retained Surgical Item	-	Monthly for Category 1														
Hosp with OT				Zero (0)	Monthly for Category 2														
Hosp with OT				Zero (0)	Monthly for Category 3														
Hosp with OT			Total no. of surgeries/procedures performed in the hospital's operation theater	-	Monthly														

MEDICATION WITHOUT HARM																				
Clinic	Hosp	3	5	Number of Medication Error leading to Severe Harm or Death	Zero (0)	Monthly														
Clinic	Hosp			Number of Actual Medication Error	-	Monthly														
Clinic	Hosp			Number of Near Miss Medication Error	-	Monthly														
	Hosp			Total no. of hospital admission (exclude clinic attendance)	-	Monthly														
Clinic	Hosp			Total no. of clinic attendance	-	Monthly														
TRANSFUSION SAFETY																				
	Hosp	4	6	Number of actual Incorrect Blood Component Transfusion Error (IBCT)	Zero (0)	Monthly														
	Hosp			Number of near miss Incorrect Blood Component Transfusion Error (IBCT)	-	Monthly														
PREVENTION OF PATIENT FALL																				
	Hosp	5	7	Rate of patient fall (inpatient) - per 1000 bed-days	≤5 per 1000 patient-days	Monthly														
Clinic	Hosp				Rate of patient fall (outpatient or clinics) - per 100 clinics attendance	≤5 %	Monthly													

PATIENT IDENTIFICATION																			
Clinic	Hosp	6	8	Number of Patient Safety incidents caused by wrong patient identification (detected through incident reporting & investigation)	Zero (0)	Monthly													
IMPLEMENTING INCIDENT REPORT AND LEARNING SYSTEM																			
Clinic	Hosp	7	9	Implementation of Incident Reporting System or other Methods To Investigate Incidents	System Implemented	Yearly	Yes / No										-	-	
Clinic	Hosp			Total no. of patient safety incident reporting done (for year of reporting).	-	Monthly													
Clinic	Hosp			Total no. of patient safety incident with severe or death outcome.	-	Monthly													
Clinic	Hosp			Total no. of patient safety incident with severe or death outcome that were investigated and action taken.	-	Monthly													

SOURCE: (MALAYSIAN PATIENT SAFETY GOALS 2.0 :MINISTRY OF HEALTH MALAYSIA 2021)

SERVICE SUMMARY

SURVEYOR SUMMARY:

OVERALL RATING:

OVERALL RISK:

SURVEY ITEM & SELF-ASSESSMENT				
SERVICE STANDARD 02: ENVIRONMENTAL AND SAFETY SERVICES				
	PREAMBLE <i>The Person In Charge (PIC) shall ensure that the Facility is provided with a range of environmental and safety programmes throughout the Facility that address safety, comfort and conducive environment to reduce risks for patients, staff and visitors to the Facility. The programmes shall cover requirements for but not limited to hazard identification, fire safety, workplace safety, disaster plans (internal and external) hazardous material management and security services.</i>			
TOPIC 2.1: STANDARD 2.1.1	ORGANISATION AND MANAGEMENT <i>All activities related to Environmental and Safety Services shall be organised and administered by the Head of the Environmental and Safety Services and coordinated by appropriate Committees so as to provide optimum support to the goals, objectives and values of the Facility and to meet the needs of the Facility, patients, staff and visitors.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
2.1.1.1 CORE	The Environmental and Safety Services shall address but not limited to the following: a) Environmental, Safety and Health b) Fire Safety c) Disaster Management i) External Disaster ii) Internal Disaster iii) Business Recovery Plan d) Hazardous Material and Recyclable Waste Management e) Security Services f) Vector and Pest Control			

	EVIDENCE OF COMPLIANCE	1. Operational policies of the Environmental and Safety Services address activities (a) to (f).				
	Facility Comments:					
2.1.1.2	The Person In Charge (PIC) shall appoint an appropriately qualified person as the Head of the Environmental and Safety Services, with clearly defined Terms of Reference, tenure, authority and responsibilities.					
	EVIDENCE OF COMPLIANCE	1. Person with appropriate qualification and experience appointed as Head of Environmental and Safety Services.				
		2. Appointment/assignment letter with job description, roles and responsibilities				
	Facility Comments:					
2.1.1.3 CORE	The PIC shall designate various Committees to monitor, execute and manage various aspects of the Environment and Safety Services. The number of Committees shall be based on the complexity of the Facility. Each of the Committee shall have an appointed Chairperson as well as adequate number of appropriately qualified Committee members. Each Committee shall have clearly defined Terms of Reference, scope of activities, and tenure of membership.					
	EVIDENCE OF COMPLIANCE	1. The Committees have:				
		a) Appointment of a Chairperson and Secretary				
		b) Terms of Reference				
		c) Committee members				
		d) Tenure of membership				
		e) Frequency of meetings				
		f) Minutes of meetings				
	Facility Comments:					

2.1.1.4	Each designated Committee shall ensure that annual action plans have been prepared based on the Terms of Reference as well as the identified needs of the patients, visitors, staff, visiting medical practitioners and the outsourced service providers, and in compliance with relevant standards, guidelines and regulations. The action plans shall be reviewed annually and as required. Each revision shall be prepared, verified and approved by authorised personnel.			
EVIDENCE OF COMPLIANCE	1. Approved yearly programme/action plan for each committee			
	2. Revision of programme as required.			
	3. Reports on implementation of yearly programme/action plan			
	Facility Comments:			
2.1.1.5 CORE	Management Committee shall oversee the structures of all ESH Committee and sub committees. Each Committee shall have an organisation chart that provides a clear representative on of the structure, functional and administrative relations with the relevant Departments/Units. The Committee organisation charts and individual organisation charts shall be approved by the PIC, and shall be accessible to all relevant Departments/Units.			
EVIDENCE OF COMPLIANCE	1. Approved Committee Organisation Charts			
	2. Organisation charts of respective Committees that are:			
	a) approved by the PIC;			
	b) accessible to all relevant Departments/Unit.			
	Facility Comments:			
2.1.1.6	Regular meetings are held between the respective appointed committee members to discuss issues and matters pertaining to the operations of the Environmental and Safety Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.			

	EVIDENCE OF COMPLIANCE	1. Minutes of meetings of Committees are accessible, disseminated and acknowledged by the staff.				
		2. Attendance list of members with adequate representatives of the service.				
		3. Frequency of meetings as scheduled				
		4. Discussions and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).				
	Facility Comments:					
2.1.1.7	There is clear evidence of coordination and cooperation amongst the various Committees pertaining to Environmental and Safety Services. Records on the coordination meetings and discussions as well as corrective and preventive actions taken shall be kept and made accessible to relevant staff when required.					
	EVIDENCE OF COMPLIANCE	1. Minutes of meetings of the main Environmental and Safety Committee and coordination meetings.				
		2. Records on corrective and preventive actions taken.				
	Facility Comments:					
2.1.1.8	The Head of Environmental and Safety Services is involved in the planning, justification and management of the budget and resource utilisation for various activities of the services.					
	EVIDENCE OF COMPLIANCE	1. Minutes of Facility-wide management meeting				
		2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service.				
		3. Approved budget and resources				
	Facility Comments:					
2.1.1.9	Appropriate statistics and records shall be maintained in relation to the provision of Environmental and Safety Services and used for managing the services and patient care purposes.					

	EVIDENCE OF COMPLIANCE	1. Records are available but not limited to the following:				
		a) workload/census;				
		b) annual report;				
		c) accident/incident reports;				
		d) staffing number and staff profile;				
		e) staff training records (Fire Safety, Occupational Safety and Health, Disaster Plans, etc);				
		f) data on performance improvement activities, including performance indicators.				
	Facility Comments:					
2.1.1.10	Where the entire Services or any part of the Services has been outsourced to any external service provider(s), the Head of the Environmental and Safety Services shall ensure that there is a written agreement between the external service provider and the Facility stating the requirements for goods and service delivery: a) formal lines of communication and responsibilities between the external service provider and the Facility; b) provision of adequate numbers of appropriately qualified personnel to perform their duties; c) participation, as appropriate, of the external service provider in the relevant Committees of the Facility; d) appropriate key performance indicators; e) arrangements for after-hours and emergency services; f) contingency plans for dealing with problems in service delivery; g) adequate facilities and equipment for providing the services; h) involvement of the external service provider in safety and performance improvement activities of the Facility, as appropriate; i) comply with the appropriate MSQH Standards of Accreditation for Environmental and Safety Services. j) All incidents and accidents occur within the outsources services shall be report to ESH Committee.					

	EVIDENCE OF COMPLIANCE	1. The Contract Agreement between the Facility and the external service provider(s) is in place and covers item (a) to (j).				
		2. Contractor's yearly performance appraisal				
		3. Fixed agenda for ESH sub committees to be discussed				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT										
TOPIC 2.2:		<u>HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT</u>								
STANDARD 2.2.1		<i>The Head of Environmental and Safety Services shall ensure the designated Committees and relevant Units/Sections/Departments are provided with adequate numbers of appropriately qualified staff as required under relevant Acts, statutory regulations and standards to achieve the objectives of the services.</i>								
		CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS					
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING				
2.2.1.1 CORE	The Chairperson and the members of the various Committees are appropriately qualified, trained, experienced and/or certified to meet the objectives of the services.									
	EVIDENCE OF COMPLIANCE	1. Certificates of qualification and registration of committee members.								
		2. Attendance to relevant training, e.g. safety officer is registered with Department of Occupational Safety and Health (DOSH) and has attended National Institute of Occupational Safety and Health (NIOSH) training.								
		3. Staff training records								
	Facility Comments:									
2.2.1.2	The authority, responsibilities and accountabilities of the Head of Environmental and Safety Services and the Chairpersons of various committees are clearly delineated and documented.									
	EVIDENCE OF COMPLIANCE	1. Appointment/assignment letter for Head of Environmental and Safety Services and chairpersons of Committees.								
		2. Terms of Reference								
	Facility Comments:									

2.2.1.3	Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the need of each committee and the Environmental and Safety Services.					
	EVIDENCE OF COMPLIANCE	1. Number of personnel meet the work requirements or as per contract (where applicable)				
		2. Qualifications of staff				
		3. Organisation chart of Environmental and Safety Services				
	Facility Comments:					
2.2.1.4	There is a structured orientation programme where new staff and contractors are briefed on general operational policies and procedures of Environmental and Safety Services and relevant aspects of the Facility to prepare them for their roles and responsibilities.					
	EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff including outsourced service providers within the Facility to attend a structured orientation programme.				
		2. Records on structured orientation programme				
		3. Orientation Module				
		4. List of attendance				
Facility Comments:						
2.2.1.5	Continuing education activities are planned and provided to all staff on Environmental and Safety Services and other requirements specific to their areas of operations, including the use of appropriate personal protective equipment (PPE), safety measures in hazardous workplaces, i.e. operating rooms, obstetrical units, emergency services, special care units, isolation rooms, central sterilising supply services, kitchens, engineering workshops, laundry as well as environmental control in the prevention of healthcare associated infections, risk identification and compliance with relevant statutory regulations.					
	EVIDENCE OF COMPLIANCE	1. Yearly training plan and programme for specific activities under the Environmental and Safety Services and additional training for hazardous workplaces.				
		2. Training schedule and course contents				
		3. List of attendance				
		4. Certificate of attendance				
Facility Comments:						

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 2.3:		<u>POLICIES AND PROCEDURES</u>				
STANDARD 2.3.1		<i>The Head of Environmental and Safety Services shall ensure that there are appropriately documented policies and procedures, which shall reflect the current knowledge and practice under the Environmental and Safety Services, and these are in compliance with relevant standards and statutory requirements.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
2.3.1.1 CORE	The Facility has a written Environmental, Health and Safety Policy statement that is displayed throughout the Facility. Other specific policies and procedures shall support and be consistent with the Environmental, Health and Safety Policy statement. These policies and procedures are signed, authorised and dated.					
	There is a mechanism for and evidence of a periodic review at least once in every three years.					
	EVIDENCE OF COMPLIANCE	1. Written, signed and dated Environmental, Health and Safety Policy.				
		2. The Policy statement poster is displayed throughout the Facility.				
		3. Documented policies and procedures for the service				
		4. Policies and procedures are consistent with regulatory requirements and current standard practices.				
		5. List of Policies and procedures that are relevant, updated, endorsed and dated.				
		6. Evidence of periodic review				
	Facility Comments:					
2.3.1.2 CORE	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, management and where required with other external service providers and with reference to relevant sources involved.					

	Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.					
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.				
		2. Minutes of meeting with evidence of cross reference with other departments.				
		3. Documented cross departmental policies				
	Facility Comments:					
2.3.1.3	Current policies and procedures are communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings				
		2. Circulation list and acknowledgement				
	Facility Comments:					
2.3.1.4 CORE	There is evidence of compliance with policies and procedures.					
	EVIDENCE OF COMPLIANCE	1. Compliance with policies and procedures through:				
		a) interview of staff on practices;				
		b) verify with observation on practices;				
		c) results of audit on practices;				
		d) practices in line with established policies and procedures.				
	Facility Comments:					
2.3.1.5	Copies of relevant policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.					
	EVIDENCE OF COMPLIANCE	1. Copies of relevant policies and procedures, protocols, guidelines, Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.				
		2. Legal Register				
	Facility Comments:					

2.3.1.6	Current reference manuals, pamphlets, journals, and books as well as information and scientific data from manufacturers concerning their products used in the service (e.g. cleaning and antiseptic agents, etc) shall be readily available for reference and guidance.					
	EVIDENCE OF COMPLIANCE	1. Hard/soft copies of relevant documents are accessible on-site and readily available for staff reference.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 2.4:		<u>FACILITIES AND EQUIPMENT</u>				
STANDARD <u>2.4.1</u>		<i>The Head of Environmental and Safety Services shall ensure adequate facilities and equipment that are safe and appropriate are available for the staff to function effectively and to meet the goals and objectives of the Environmental and Safety Services.</i>				
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
2.4.1.1	There are adequate and appropriate facilities and equipment with proper utilisation of space to enable staff to carry out their professional and administrative functions.					
	EVIDENCE OF COMPLIANCE	1. Adequate facilities and proper utilisation of space within the Facility for staff and outsourced service providers to carry out activities that affected by Environmental and Safety Services:				
		a) adequate rooms/cabinets/work desks/ workshop areas;				
		b) adequate storage space;				
		c) no congestion is observed;				
		d) Biannual Occupancy Evaluation Risk Assessment reports. The report shall include a), b) and c) above.				
	Facility Comments:					
2.4.1.2	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.					
	EVIDENCE OF COMPLIANCE	1. Testing, commissioning and calibration records (certificates or stickers)				
		2. Certificates of calibration, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc.				
		3. Certification of equipment - Certificate of fitness (Department of Occupational Safety and Health certification, Fire Authority)				
	Facility Comments:					

2.4.1.3 CORE	Where specialised equipment (equipment that is high risk, require competency training and/or, complying to regulatory requirements) is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.				
	EVIDENCE OF COMPLIANCE	1. List of personnel authorised by the Person In Charge (PIC) to operate specialised equipment.			
		2. Training records			
		3. Staff profile of authorised personnel			
		4. Competency assessment records			
		5. Certificate/registration of competent person as required or letter of authorisation.			
	Facility Comments:				
2.4.1.4	Provisions are made for the personal comfort of patients, visitors and staff. These include clean and hygienic facilities, appropriate room temperature and relative humidity and permissible noise levels.				
	EVIDENCE OF COMPLIANCE	1. Environmental audit reports			
		2. Patient satisfaction survey reports			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT								
TOPIC 2.5:		SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES						
STANDARD 2.5.1		The Head of Environmental and Safety Services shall ensure performance improvement with staff involvement in continuous safety and performance improvement activities of the Environmental and Safety Services. This can be achieved through monitoring and tracking of Hazard Identification, Risk Assessment and Risk Control (HIRARC) activities. The Head of Environmental and Safety Services shall ensure compliance to monitoring of specific performance indicators.						
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS				
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING			
2.5.1.1 CORE	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Environmental and Safety Services. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.							
	EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to (f)						
		2. Records on performance improvement activities						
		3. Minutes of performance improvement meetings						
		4. Performance improvement studies						
		5. Records on innovation if available						
	Facility Comments:							
2.5.1.2	The Head of Environmental and Safety Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement activities to appropriate individual/personnel within the respective committees/activities.							

	EVIDENCE OF COMPLIANCE	1. Minutes of meetings				
		2. Letter of assignment of responsibilities				
		3. Terms of Reference/job description				
	Facility Comments:					
2.5.1.3 CORE	The Head of Environmental and Safety Services shall ensure that the staff are trained and complete incident reports involving patients, staff, visitors and outsourced service providers which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility.					
	Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.					
	EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:				
		a) Training of staff				
		b) Procedure on incident/accident reporting				
		c) Methodology of incident reporting				
		d) Register/records of incidents				
		2. Completed incident reports				
		3. Root Cause Analysis				
		4. Corrective and preventive action plans				
		5. Remedial measure, Review of remedial measure for further improvement				
		6. Reports to Relevant Authorities as required				
	7. Minutes of meetings of ESH Committee					
	8. Acknowledgment by Head of Service and PIC/Hospital Director					
	9. Feedback given to staff regarding incident reporting.					
	Facility Comments:					

2.5.1.4 CORE	There is tracking and trending of specific performance indicators not limited to but at least two (2) of the following:					
	a) percentage of issues identified during Environmental and Safety Audit are closed or followed through. (Proposed Initial Target: 50%, 3 monthly report)					
	b) percentage of internal and external planned drill are carried out and documented including recommendation and followed through. (Target: 100%)					
	c) percentage of workplace hazards identified and risk managed (Target: 100%)					
	EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored.				
		2. Records on tracking and trending analysis				
		3. Records on workplace inspection and drills				
4. Records on analysis on Hazard Identification, Risk Assessment and Risk Control (HIRARC)						
5. Remedial measures taken where appropriate						
Facility Comments:						
2.5.1.5	Feedback on results of safety and performance improvement activities are regularly communicated to the staff and relevant authority.					
	EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff.				
		2. Evidence of feedback via communication on results of performance improvement activities through continuing education activities/meetings.				
		3. Minutes of committee meetings				
		Facility Comments:				
2.5.1.6	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.					

	EVIDENCE OF COMPLIANCE	1. Documentations on performance improvement activities and performance indicators.				
		2. Policy statement on anonymity on patients and providers involved in performance improvement activities.				
	Facility Comments:					
2.5.1.7 CORE	There are safety and performance improvement activities that address staff safety including the staff of the outsourced service providers.					
	EVIDENCE OF COMPLIANCE	1. Staff health screening				
		2. Identification of health risk factors				
		3. Infectious diseases prevention programme/activities				
		4. Anti-smoking programme				
		5. Healthy lifestyle campaign				
		6. Staff training on:				
		a) sharps and needle stick injury management;				
		b) Occupational Safety and Health;				
		c) ergonomics;				
		d) biohazard waste disposal.				
		7. Medical check-up record.				
		8. Post exposure management				
		9. Universal/standard precautions				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT	
TOPIC 2.6:	<u>SPECIAL REQUIREMENTS</u>
STANDARD <u>2.6.1</u>	<u>ENVIRONMENT, SAFETY AND HEALTH PROGRAMMES</u> <i>The Management of the Facility promotes Environment, Occupational Safety and Health programmes that ensure a safe and healthy environment for patients, staff, visitors and outsourced service providers.</i>

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
2.6.1.1 CORE	There is a multidisciplinary Environmental Safety and Health (ESH) Committee for the purpose of planning, implementing and maintaining a comprehensive workplace safety programme including monitoring and reporting on incidents and accidents related to workplace safety and health of staff, in compliance with the Environmental Quality Act 1974 (Act 127) and Occupational Safety and Health Act (OSHA) 1994.				
	EVIDENCE OF COMPLIANCE	1. ESH Committee is established.			
		2. Organisation chart of ESH Committee			
		3. Terms of Reference of the ESH Committee			
		4. Schedule of meetings for the year			
		5. Minutes of meetings			
	Facility Comments:				
2.6.1.2	The Environmental Safety and Health (ESH) Committee shall be headed by top Management and supported by a Safety and Health Officer (SHO) registered with Department of Occupational Safety and Health (DOSH). The composition of the committee shall follow Occupational Safety and Health Act (OSHA) 1994 and Environmental Quality Act 1974 requirements. The letter of appointments shall clearly define the authority, responsibilities and accountabilities for the committee members.				
	EVIDENCE OF COMPLIANCE	1. Composition of the Committee is in accordance to the OSH Act 1994:			
		a) the Chairman of the committee shall be PIC/CEO			
		b) the secretary of the committee shall be the Safety and			

		Health Officer;				
		c) members are representatives of employees and employers from multidiscipline.				
		2. Letter of appointment				
		3. Job Scope as per Term of Reference				
	Facility Comments:					
2.6.1.3	There shall be Terms of Reference for the ESH Committee and clear committee organisational structure that shows coordinating functions between ESH Committee and specific subcommittees.					
	EVIDENCE OF COMPLIANCE	1. ESH Committee's organisation chart showing coordination with other specific committees.				
		2. Committee's Terms of Reference				
	Facility Comments:					
2.6.1.4 CORE	There are planned activities that monitor and evaluate the performance of occupational safety and health programme. These activities include:					
	a) conducting regular multidisciplinary environmental and safety inspections to ensure the workplace is safe, conducive, and comfortable to the staff, patients and visitors. The inspections shall be based on appropriate safety inspection checklists which shall include but not limited to: i) general safety on fire safety, facility, equipment and systems that pose risks; indoor air quality concerns; ii) security and comfort of occupants and; iii) hazardous materials management. b) the frequency of the environmental and safety inspections shall be in compliance with statutory regulations and professional best practices as determined by the ESH Committee;					
	c) to promote healthy work culture programme and to conduct staff health surveillance especially to staff involved in high occupational hazards;					

	d) conduct comprehensive risk assessment that includes identification of high risk areas, maintaining Risk Registers, carrying out Failure Mode and Effect Analysis (FMEA) and taking appropriate corrective actions to rectify the identified risks; e) investigation on reported incidents and accidents using Root Cause Analysis (RCA); f) To plan for recovery process if required to ensure business continuity g) follow-up action taken to evaluate the effectiveness of the corrective actions taken on identified high risks and on reported incidents and accidents to close the gap; h) reporting of OSH activities as required by law and regulations. i) Promote sustainability programmes that includes efficiency of use of energy, water, climate, and waste. Note <i>Risk register is taken to mean a register which records details of all the risks identified for an organisation, their grading in terms of likelihood of occurring and seriousness of impact on the organisation, initial plan for managing each high-level risk and subsequent results.</i>			
	EVIDENCE OF COMPLIANCE	1. Environment and Safety audit schedule and reports		
		2. Risk Register and risk assessment report		
		3. Health Promotion programme		
		4. Staff health surveillance record and statistics		
		5. Minutes of meetings, reports and records on environmental, occupational safety and health activities.		
		6. Incident reports and RCAs		
		7. Business Continuity Report on follow-up actions for further improvements		
		8. Corrective and preventive measures		
		9. Reports to relevant authorities, e.g., sharps injury to Ministry of Health, Lost Time Accident to Department of Occupational Safety and Health.		
		10. Recovery plan for Business Continuity		
		11. Sustainability Program		
	Facility Comments:			

2.6.1.5 CORE	There is a Safety and Health Officer whose authority, responsibilities and accountabilities for safety related activities are clearly defined and documented in a letter of appointment.					
	EVIDENCE OF COMPLIANCE	1. Valid registration of Safety and Health Officer with Department of Occupational Safety and Health (DOSH).				
		2. Appointment of Safety and Health Officer				
		3. Job description				
	Facility Comments:					
2.6.1.6	There is evidence that all staff are familiar with workplace environmental, safety and health programmes.					
	EVIDENCE OF COMPLIANCE	1. Orientation checklist				
		2. Attendance list				
		3. Contents of orientation programme to include environmental, safety and health programme.				
		4. Brochures, pamphlets and leaflets				
		5. Staff knowledgeable on risks and hazards at their workplace.				
		6. Staff comply with environmental, safety requirements				
	Facility Comments:					
2.6.1.7	There are written environmental and safety procedures specific to potentially hazardous areas and for hazardous substances (for example, central sterilising supply services, food services areas, laundries, laboratories, operating suites, radiation emission areas, special units, engineering rooms and workshops).					
	EVIDENCE OF COMPLIANCE	1. Departmental specific environmental and safety policies and procedures that include the following:				
		a) Central Sterilising Supply Services (CSSS)				
		b) Food Services				
		c) Laundry				

		d) Laboratory				
		e) Operating suite				
		f) Radiation Emission Areas				
		g) Engineering rooms/workshop				
		h) Laser safety program				
	Facility Comments:					
2.6.1.8	Special environmental and safety measures for facilities and equipment operation and maintenance are enforced for hazardous areas in accordance with applicable standards and the requirements of national and local statutory authorities. Written environmental and safety instructions and notes are readily available.					
	EVIDENCE OF COMPLIANCE	1. Operation and maintenance of environmental and safety policies and procedures and work instructions e.g. Permit to Work/Construction Permit/Confine Space Entry Permit/LOTO				
		2. Records on staff training				
		3. Procedure checklist				
	Facility Comments:					
2.6.1.9	Personal protective clothing and equipment are provided where required, and their usage is monitored.					
	Staff are provided with vaccination and/or medication as necessary to perform their work safely.					
	EVIDENCE OF COMPLIANCE	1. Adequate supply of Personal Protective Equipment (PPE) and monitor stock balance.				
		2. Staff wear proper PPE.				
		3. Staff's vaccination record				
	Facility Comments:					

2.6.1.10	The following are standard environmental and safety practices that shall be complied with as follows: a) All portable gas cylinders are stored, restrained, and secured in accordance with applicable standards and the requirements of national and local statutory authorities. The requirements are: i) oxygen and flammable gases are stored separately from each other. ii) storage areas are ventilated, built of non-combustible material, and secured as appropriate. iii) all gas cylinders are restrained and stored in an upright position. iv) storage areas are appropriately labelled/sign posted including “No Smoking” sign in accordance with statutory requirements. b) There is provision of emergency suction apparatus and medical gas supplies in key areas such as operating suites, special care units, emergency services, etc. c) There has to be adequate lightings to service areas and there is provision of alternative light (emergency portable lightings) appropriate to the needs of the Facility in the event of a failure of the local supply.				
	EVIDENCE OF COMPLIANCE	1. Compliance with items (a) to (c) by the Facility.			
	Facility Comments:				
2.6.1.11	The Facility shall ensure that noise, excessive smoke, foul odour or dust are minimised with evidence of surveillance report.				
	EVIDENCE OF COMPLIANCE	1. Noise mapping			
		2. Indoor air quality report			
		3. Evidence of follow-up and follow through from recommendations made in the report			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT						
STANDARD 2.6.2	<u>FIRE SAFETY</u> <i>All buildings within the Healthcare Facility shall be designed, constructed, equipped, operated and maintained in compliance with the relevant Acts, Statutory Regulations and Standards, ensuring safety to patients, visitors, staff and property from damages due to fire.</i>					
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
2.6.2.1 CORE	The building shall be equipped with active and passive protection system such as fire detection and suppression system, in compliance with statutory regulations, standards and professional best practices relating to fire safety. The fire detection systems shall be integrated and linked to the nearest fire station designated by the Fire Authority. Note: Refer to Fire Services Act 1988					
	EVIDENCE OF COMPLIANCE	1. Building drawing approved by Fire Authority				
		2. Continuous Monitoring Information System (CMIS) is functional and linked to the fire station where applicable.				
	Facility Comments:					
2.6.2.2 CORE	For all new buildings, renovation works and alterations to systems, there has to be documented evidence that the Fire Authority has approved the layout plan for fire safety. The drawings and design calculations shall be endorsed by Professional Engineer and/or Registered Architect.					
	EVIDENCE OF COMPLIANCE	1. Approved as built drawings by relevant professionals.				
		Facility Comments:				

2.6.2.3 CORE	There is documented evidence that all buildings have been inspected by the Fire Authority annually and all risk issues identified during the inspections have been rectified to the satisfaction of the Fire Authority concerned. Note: Refer to Fire Service Act 1988												
	<table><tr><td rowspan="3">EVIDENCE OF COMPLIANCE</td><td>1. Annual fire inspection report by Fire Authority</td><td></td></tr><tr><td>2. Current Fire Safety Certificate is available for buildings</td><td></td></tr><tr><td>3. Facility's report on rectification of recommendations by Fire Authority where required.</td><td></td></tr></table>	EVIDENCE OF COMPLIANCE	1. Annual fire inspection report by Fire Authority		2. Current Fire Safety Certificate is available for buildings		3. Facility's report on rectification of recommendations by Fire Authority where required.						
EVIDENCE OF COMPLIANCE	1. Annual fire inspection report by Fire Authority												
	2. Current Fire Safety Certificate is available for buildings												
	3. Facility's report on rectification of recommendations by Fire Authority where required.												
	Facility Comments:												
2.6.2.4 CORE	Fire fighting equipment/system, such as fire extinguishers, hydrants, hose reels, fire blankets and fire suppression system are located at appropriate locations as per Fire Authority's requirements. The fire alarm systems are in proper functioning condition, and are being maintained and tested regularly, at least once every three (3) months or as required.												
	<table><tr><td rowspan="4">EVIDENCE OF COMPLIANCE</td><td>1. Fire extinguishers have valid inspection certificates.</td><td></td></tr><tr><td>2. Testing of fire extinguishers</td><td></td></tr><tr><td>3. Maintenance records</td><td></td></tr><tr><td>4. Functional fire alarm system</td><td></td></tr></table>	EVIDENCE OF COMPLIANCE	1. Fire extinguishers have valid inspection certificates.		2. Testing of fire extinguishers		3. Maintenance records		4. Functional fire alarm system				
EVIDENCE OF COMPLIANCE	1. Fire extinguishers have valid inspection certificates.												
	2. Testing of fire extinguishers												
	3. Maintenance records												
	4. Functional fire alarm system												
	Facility Comments:												
2.6.2.5	There are clear signages to indicate the location of fire fighting equipment and general instructions to use the equipment during emergency.												
	<table><tr><td rowspan="1">EVIDENCE OF COMPLIANCE</td><td>1. Signages indicating fire fighting equipment are clearly visible.</td><td></td></tr></table>	EVIDENCE OF COMPLIANCE	1. Signages indicating fire fighting equipment are clearly visible.										
EVIDENCE OF COMPLIANCE	1. Signages indicating fire fighting equipment are clearly visible.												
	Facility Comments:												

2.6.2.6	For passive fire protection, the buildings shall be compartmentalised appropriately to minimise the risk of the spread of fire and smoke. There are no open penetrations on walls, ceilings or walls to avoid smoke ingress.				
	EVIDENCE OF COMPLIANCE	1. No penetrations at fire walls and zone compartments.			
	Facility Comments:				
2.6.2.7	All doors, corridors, ramps, and emergency stairways along the designated fire escape routes shall be kept free of obstruction at all times and are minimally 2.1 meters to allow for the evacuation of non-ambulatory patients, in compliance with relevant statutory regulations.				
	EVIDENCE OF COMPLIANCE	1. Fire exit routes are unobstructed			
	Facility Comments:				
2.6.2.8	All fire doors shall be kept closed at all times (no door stopper allowed), except where permitted otherwise. In such cases, the fire doors may be held open by electrically operated door holder devices which can be set to release upon activation of the fire detection system. Fire doors shall not swing into the corridors.				
	EVIDENCE OF COMPLIANCE	1. Fire doors kept closed at all times.			
	Facility Comments:				
2.6.2.9	All fire escape routes and fire exit doors shall be identified with lighted “KELUAR” or “EXIT” sign as stipulated in the Fire Authority’s regulations.				

	EVIDENCE OF COMPLIANCE	1. Lighted KELUAR / EXIT signs are:			
		a) clearly visible from any internal corridors			
		b) functional;			
		c) adequate.			
	Facility Comments:				
2.6.2.10 CORE	The evacuation route floor plans shall be displayed at the entrances of every department. The assembly areas have to be a secured open space at a safe distance away from the building. There is signage to direct evacuees to the assembly area in case the assembly areas could not be seen when evacuees exiting the building.				
	EVIDENCE OF COMPLIANCE	1. Current evacuation plans are available.			
		2. Clear signage to assembly areas			
	Facility Comments:				
2.6.2.11	There are adequate "No Smoking" signs posted at all entrances to the Facility.				
	EVIDENCE OF COMPLIANCE	1. No Smoking" signs are:			
		a) visible;			
		b) adequate;			
		c) placed at all entrances to the Facility.			
	Facility Comments:				
2.6.2.12 CORE	There is at least one designated Fire Safety Officer assigned by the Person In Charge for every shift. The Fire Safety Officer(s) shall have the relevant training to ensure that they can be responsible for fire safety at the Facility all times.				
	EVIDENCE OF COMPLIANCE	1. Assignment letter			
		2. Fire Response Training records			
		3. Minutes of fire safety meetings			
	Facility Comments:				

2.6.2.13 CORE	The Emergency Response Team (ERT) and key Incident Management Team (IMT) shall be adequately equipped to respond during emergency.					
	EVIDENCE OF COMPLIANCE	1. ERT and IMT are established.				
		2. Emergency procedures and disaster control room facilities are available.				
		3. Training records				
		4. Minutes of fire safety meetings				
	Facility Comments:					
2.6.2.14 CORE	The fire evacuation plans and procedures shall include: a) the assignment of personnel to specific tasks and responsibilities, e.g. IMT,ERT, floor wardens, etc; b) instructions for the use of alarm systems and signals; c) information concerning methods of fire containment and suppressions; d) information concerning the location of fire fighting equipment; e) systems for notification of appropriate persons; f) evacuation process, maps on evacuation routes, assembly points; g) head count process; h) activation of the fire emergency plans (Code Red) or other emergency plans where warranted; i) ensure smooth recovery back to normal operation j) if major fire incident, business recovery plan should be activated k) other provisions as the local situation dictates.					
	EVIDENCE OF COMPLIANCE	1. Approved fire evacuation and recovery plan and procedures that include items (a) to (k).				
		2. Staff awareness on fire evacuation plan and procedures				
		3. Staff assignment and response card				
		4. Training records for all staff including on-site outsourced staff including				
	Facility Comments:					

2.6.2.15 CORE	There is documented evidence that fire drills had been planned and executed every year (minimum once a year) involving different Units/Sections/Departments and conducted under varied conditions. Major evacuation has to be done with the assistance of the local Fire Authority (BOMBA). There are written reports and evaluations on all drills, and documentation of staff attendances.									
	<table><tr><td>EVIDENCE OF COMPLIANCE</td><td>1. Records and reports on annual fire drills</td><td></td></tr><tr><td></td><td>2. Staff attendance list</td><td></td></tr></table>	EVIDENCE OF COMPLIANCE	1. Records and reports on annual fire drills			2. Staff attendance list				
EVIDENCE OF COMPLIANCE	1. Records and reports on annual fire drills									
	2. Staff attendance list									
	Facility Comments:									
2.6.2.16	The general contingency plan for fire and evacuation shall be understood by all staff and on-site outsourced staff and tenants. Key assigned personnel shall be trained in more advanced aspects of fire safety, including fire notification procedures, fire alarm, use of fire fighting equipment, fire evacuation procedures and evacuation of non-ambulant patients.									
	<table><tr><td>EVIDENCE OF COMPLIANCE</td><td>1. Staff awareness on fire and evacuation plan</td><td></td></tr><tr><td></td><td>2. Records on training of key assigned personnel and staff on specific aspects of fire safety</td><td></td></tr></table>	EVIDENCE OF COMPLIANCE	1. Staff awareness on fire and evacuation plan			2. Records on training of key assigned personnel and staff on specific aspects of fire safety				
EVIDENCE OF COMPLIANCE	1. Staff awareness on fire and evacuation plan									
	2. Records on training of key assigned personnel and staff on specific aspects of fire safety									
	Facility Comments:									

SURVEY ITEM & SELF-ASSESSMENT			
STANDARD 2.6.3	<u>DISASTER MANAGEMENT</u> <i>The Facility has written plans to deal with internal and external disasters. Plans are coordinated with statutory and civil authorities as appropriate. The Person In Charge (PIC) of the Healthcare Facility shall ensure there are documented contingency plans to deal with identified disasters, in compliance with the relevant statutory regulations, and as follows:</i>		
	a) <i>External Disaster Plan (also classified as Community Affected – Healthcare Facility Unaffected): during such scenarios, the Healthcare Facility plays a vital role in the disaster response being undertaken. For the Healthcare Facility, such scenarios would imply a sudden increase in demand for patient care services because of the surge in the number of patients seeking medical attention. There is a possibility of the Healthcare Facility getting overwhelmed if adequate preparedness and response mechanisms are not swung into action as soon as the disaster is reported.</i> b) <i>Internal Disaster Plans (also classified as Community Unaffected – Healthcare Facility Affected): Such scenarios arise from the internal disasters within the Healthcare Facility. As such, partial or complete evacuation and transfer of critical patients to networking facilities is the key to successful response. Such scenarios also demand a high degree of preparedness on the side of the Facility administration and staff, as well as a speedy response from the surrounding community and Healthcare Facilities.</i> c) <i>Business Recovery Plan – For both internal and external disasters, business recovery plan shall be available for the facility to normalcy after the event.</i> <i>It should be noted that the Healthcare Facility may experience sudden loss of essential services, such as water supply, electricity, medical gases, telephone services, etc. Hence, the Healthcare Facility should have appropriate contingency plans for such interruptions, ensuring that the workplace safety is not compromised.</i>		
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT
			SURVEYOR RATING
2.6.3.1	<u>EXTERNAL DISASTER PLANS</u> <i>The Facility has an appropriate external disaster plan, based on its capabilities and as follows:</i> a) <i>the external disaster plan is developed in consultation with relevant statutory and civil authorities, relevant Non-Governmental Organisations and other service agencies supporting the locality. The plan is to establish an effective chain of</i>		

	command, clarify matters of jurisdiction, and coordinate the Facility's activities with the activities of these agencies. Where deemed necessary, a standing External Disaster Committee shall be established, with the Chairperson being appointed in writing by the Person In Charge (PIC); b) the scope of the Facility's roles and resources shall be made known to the local police, Fire Authority, the state emergency services, associated supporting ambulance teams, other healthcare facilities and the community; c) the disaster plan provides for: i) consideration of the type of disasters likely to occur; ii) limits of casualties when the disaster plan should be activated; iii) defined authority and control; iv) assignment of staff to specific tasks and responsibilities; v) identification for staff involved in the plan (e.g. special vest, etc); vi) an efficient system of notifying staff (response card); vii) effective communication systems within and outside the Facility; viii) availability of adequate basic utilities and supplies including gas, water, electricity, food, and essential medical and support materials; ix) conversion of all appropriate spaces into clearly defined areas for efficient triage, patient observation and immediate care; x) transportation arrangements when necessary for prompt transfer of casualties to the Facility most appropriate for administering definitive care, after preliminary emergency medical or surgical services have been rendered; xi) making available a list of casualties and appropriately designed tags to accompany each casualty; xii) arrangements for the prompt discharge or transfer of current inpatients who can be moved without harm; xiii) maintaining security in order to keep unauthorised persons away from the triage area; xiv) the establishment of a public information centre and assignment of public relations duties to a suitable person; a media communication plan will help to provide organised dissemination of information; xv) debriefing and disaster plan review procedures. d) the external disaster plan involving the medical practitioners, other relevant staff and external agencies such as the police, Fire Authority, etc and shall be tested for its capability at least once a year in order to: i) ensure that all responsible staff are provided with training to enable performance of assigned tasks; ii) evaluate the effectiveness of the plan;			

	iii) evaluate and document the exercise; iv) review and revise the plan as necessary.					
	EVIDENCE OF COMPLIANCE	1. External Disaster Plan that addresses items (a) to (c).				
		2. List of relevant agencies and their contact numbers				
		3. Adequate resources as per disaster plan				
		4. Records on relevant staff training on the disaster plan				
		5. Staff response card				
		6. Drills and training records				
		7. Reports on the Disaster Drill and actual disaster (if applicable)				
		8. Evaluation on Disaster Drill and actual disaster (if applicable)				
		9. Revision of External Disaster Plan as necessary				
Facility Comments:						
2.6.3.2 CORE	INTERNAL DISASTER PLANS The Facility shall have documented internal disaster plans for all anticipated occurrence of incidences that would have adverse effect on patients, visitors and staff as follows: a) Fire/Explosion b) Bomb threat c) Evacuation d) Physical Assault/Security Threat e) Baby abduction f) Facilities system failure including IT Systems g) Major chemical spillage/radiation leaks h) Medical Emergencies i) Emergencies in Delivery Suite and Operating Rooms j) Biological threats including infectious disease A code system normally using colour as identifier is used to identify the emergency status to avoid unnecessary panic if the code is announced via public address system.					
EVIDENCE OF COMPLIANCE	1. Internal Disaster Plan that include potential internal disasters (a) to (i).					
	2. Internal Disaster Plan with specified colour codes					
	3. List of relevant agencies and their contact numbers					
	4. Adequate resources as per disaster plan					
	5. Records on relevant staff training on the Internal Disaster Plan					
	6. Staff response card					

		7. Reports on the Disaster Drill and actual disaster (if applicable)				
		8. Revision of Internal Disaster Plan as necessary				
	Facility Comments:					
2.6.3.3 CORE	(a) The Internal Disaster Plan shall include but not limited to:					
	i) establishment of disaster management team with clear reporting line;					
	ii) activation of the plans and disaster command centre;					
	iii) assignment of personnel to specific tasks and responsibilities;					
	iv) instructions for the use of alarm systems and signals;					
	v) information concerning methods of hazards management and area isolation, e.g. fire containment;					
	vi) information concerning the location of emergency equipment, e.g. fire fighting equipment, fire protected lobby, etc;					
	vii) systems for notification of appropriate persons/authority and/or announcement to public or groups;					
	viii) maps on evacuation routes and directional signage for assembly areas;					
	ix) requirements for medical support for mass casualties, e.g. medical based for resuscitation area or handling trauma;					
	x) post event management, e.g. investigation, insurance, relevant authorities, relatives, etc;					
	b) The internal disaster plans are tested for its capability at least once a year in order to:					
	i) ensure that all staff are provided with training to enable performance of assigned tasks;					
	ii) evaluate the effectiveness of the plan;					
	iii) evaluate and document the exercise;					
	iv) review and revise the plan as necessary.					
	c) The Internal Disaster Plan shall be readily available for staff reference.					
	d) Staff are familiar with the internal disaster plans and shows understanding of the plans that are displayed throughout the Facility.					
EVIDENCE OF COMPLIANCE	1.	Appropriate Internal Disaster Plan that addresses items (a)(i) to (a)(x).				
	2.	Designated Command Centre				
	3.	Drills and training records				
	4.	Reports on the Disaster Drill and actual disaster (if applicable)				
	5.	Evaluation on Disaster Drill and actual disaster (if applicable)				
	6.	Revision of Internal Disaster Plan as necessary				

		7. Control copy of Internal Disaster Plan is easily accessible to staff.					
		8. Staff awareness on Internal Disaster Plan					
	Facility Comments:						
2.6.3.4	Disaster Recovery Plan shall be formulated for all major disasters that affected normal hospital service operation including the following: a. Effort to restore operation to normalcy and repair damages to its original condition b. To ensure that aspects of physical and mental health of patients, family members and staff been taken care of. c. To conduct post mortem to identify better precautionary steps and improving the disaster management process d. Continuously improve the preventive and mitigation measures in recovery plan for the future						
	EVIDENCE OF COMPLIANCE	1. Appropriate Business Recovery Plan that addresses item 1 to 5					
		2. Reports of business recovery after disaster					
	Facility Comments:						

SURVEY ITEM & SELF-ASSESSMENT						
STANDARD 2.6.4	<u>HAZARDOUS MATERIAL MANAGEMENT</u> <i>Hazardous materials include chemicals, radioactive materials and scheduled waste. Handling of chemicals including the collection, storage, transportation and disposal of all healthcare wastes shall be properly managed in compliance with relevant statutory regulations (such as the Environmental Quality Act 1974 (Act 127) and subsequent amendments and the subsidiary legislation referring to scheduled waste, prescribed premises, prescribed activities, Prevention and Control of Infectious Diseases Act 1988, Atomic Energy Licensing Act 1984, etc) and professional best practices as agreed by the Environmental and Safety Committee.</i>					
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
2.6.4.1 CORE	All chemicals and types of healthcare wastes (clinical, cytotoxic, radioactive, spent reused oil etc.) shall be defined, identified and labelled appropriately as required.					
	EVIDENCE OF COMPLIANCE	1. Valid report on Chemical Health Risk Assessment by competent person.				
	Facility Comments:					
2.6.4.2 CORE	Staff that handle chemicals and healthcare facility wastes need to be trained on proper handling and disposal of such wastes.					
	EVIDENCE OF COMPLIANCE	1. Records on staff training				
	Facility Comments:					
2.6.4.3	Staff shall wear appropriate personal protective equipment when handling hazardous materials.					

	EVIDENCE OF COMPLIANCE	1. Staff and contractors wear appropriate personal protective equipment.				
	Facility Comments:					
2.6.4.4	Staff shall be trained to handle spillage and appropriate spill kits are located appropriately.					
	EVIDENCE OF COMPLIANCE	1. Policy and procedures on handling spillage				
		2. Staff able to demonstrate the procedures on handling spillage				
		3. Adequate spillage kits are available.				
	Facility Comments:					
2.6.4.5 CORE	Wastes requiring special processing (such as radioactive, cytotoxic and sharps) shall be segregated at the point of origin, appropriately labelled during collection in compliance with the relevant regulations and guidelines, collected in approved colour-coded bags and sharps containers by appropriately trained staff, stored in designated storage facility with proper temperature controls, and with hand washing facility and wastewater drainage.					
	EVIDENCE OF COMPLIANCE	1. Chemical and scheduled wastes are properly labelled and not mixed with other wastes.				
		2. Appropriate storage facilities for:				
		a) clinical waste;				
		b) chemical and chemical waste;				
		c) electronic waste;				
		d) radioactive waste.				
		3. Eyewash and shower for chemical handling				
		4. Handwashing facilities				
	Facility Comments:					

2.6.4.6	Chemicals and healthcare wastes shall be appropriately stored as follows: a) inflammable, acid/base chemicals shall be kept separately in metal cabinets; b) the chemical and scheduled waste store shall be well ventilated and equipped with spillage containment; c) the clinical waste store shall be refrigerated if the wastes are stored for more than 24 hours.					
	EVIDENCE OF COMPLIANCE	1. Proper storage including containment of chemicals in appropriate and right size cabinets and/or rooms.				
		2. Clinical waste store is refrigerated at temperature 4°C - 6°C if the wastes are stored for more than 24 hours.				
	Facility Comments:					
2.6.4.7	There has to be a dedicated route for waste transportation. No mixing between clean and dirty waste materials.					
	EVIDENCE OF COMPLIANCE	1. Policy and procedures address the route/timing of waste transportation.				
		2. Dedicated route for transportation of waste.				
	Facility Comments:					
2.6.4.8 CORE	All scheduled wastes shall be transported to the final disposal site in dedicated vehicles licensed by the Department of Environment.					
	EVIDENCE OF COMPLIANCE	1. Approval letter from Department of Environment for transporting scheduled waste outside the premises.				
		2. Consignment note available.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT				
STANDARD 2.6.5	<u>DOMESTIC AND RECYCLED WASTE</u> <i>The disposal of domestic and recycled wastes is carried out in accordance with legislation requirements of the Department of Environment and local authority.</i>			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT
				SURVEYOR RATING
2.6.5.1	Domestic, recycled and food wastes shall be removed daily and the main storage area shall be kept clean.			
	EVIDENCE OF COMPLIANCE	1. Domestic, recycled and food wastes areas are kept clean.		
		2. Schedule on collection of domestic, recycled and food wastes from local authority/local contractors.		
	Facility Comments:			
2.6.5.2	Recycle waste shall be separated at source using the designated containers. No waste segregation is allowed at the central waste storage.			
	EVIDENCE OF COMPLIANCE	1. Policy and procedures for recycling waste		
		2. Compliance with policy and procedures		
	Facility Comments:			

SURVEY ITEM & SELF-ASSESSMENT							
STANDARD 2.6.6		<u>SECURITY SERVICES</u> <i>Security measures are taken to ensure the protection of patients and staff from assault and loss of property; and the Facility from damage and loss.</i>					
		CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
2.6.6.1 CORE	Regular security risk assessment shall be carried out by a Committee appointed by the Person In Charge so as to identify potential security risks in the Facility.						
	EVIDENCE OF COMPLIANCE	1. Valid Security Risk Assessment Report					
	Facility Comments:						
2.6.6.2 CORE	Appropriate security measures shall be taken to ensure the protection of patients, staff and visitors. These may include staff, visitors and contractors access control, closed-circuit television (CCTV) monitoring, key control, duress alarm systems, adequate lighting, and security protection for personal belongings, payroll, drugs, and other assets of the Facility.						
	EVIDENCE OF COMPLIANCE	1. Functional security system is available, e.g. card access, CCTV, locks, barrier, lighting, duress alarm, etc.					
		2. Recommend CCTV to have minimum 14 days of storage capacity					
		3. Procedure and practice of control access after visiting hours					
		4. Reports on performance of the security system					
		5. Security incident reports					
	Facility Comments:						

2.6.6.3	There are adequate and well trained security personnel for the Facility such that the presence of security is felt to deter potential criminal activities.				
	EVIDENCE OF COMPLIANCE	1. Security personnel is present at important areas at all times.			
		2. Records on clearance from Ministry of Internal Affairs for all security personnel			
		3. Training records on security personnel			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT						
STANDARD 2.6.7	<u>VECTOR AND PEST CONTROL SERVICES</u> <i>Healthcare buildings are ideal places for the breeding of various categories of vectors and pests such as insects (ants, termites, cockroaches, flies, etc.), rodents (rats, mice, etc.) and stray animals (dogs, cats, snakes, etc). Healthcare Facilities infested by vectors and pests can be high risks for transmitting of infections and diseases.</i>					
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
2.6.7.1 CORE	There is documented evidence that a comprehensive vector and pest control programme throughout the hospital including tenanted areas is being implemented in a scheduled manner and monitored regularly.					
	EVIDENCE OF COMPLIANCE	1. Vector and pest control schedule as per agreement and records on activities.				
	Facility Comments:					
2.6.7.2	Vector and pest control includes the extermination and control of unwanted insects (ants, termites, cockroaches, mosquitoes, etc.) and rodents (rats, etc.), as well as removal of stray animals (cats, dogs, birds, etc.). Some of the vector and pest control activities have to be scheduled as per agreement and approval of the Healthcare Facility Management. Vectors and pests shall not be seen in the facility buildings and grounds.					
	EVIDENCE OF COMPLIANCE	1. No vectors and pests seen in the facility buildings and grounds.				
	Facility Comments:					

2.6.7.3	There is planned regular vector control programme.					
	EVIDENCE OF COMPLIANCE	1. Dengue control activities				
		2. Records on inspection of mosquito breeding areas				
	Facility Comments:					

SERVICE SUMMARY	
SURVEYOR SUMMARY:	
OVERALL RATING:	
OVERALL RISK:	

SURVEY ITEM & SELF-ASSESSMENT				
SERVICE STANDARD 3: FACILITY AND BIOMEDICAL EQUIPMENT MANAGEMENT AND SAFETY				
	<u>PREAMBLE</u> <i>The Person In Charge (PIC) shall ensure that the Healthcare Facility is provided with safe, functional and support facilities and equipment for its patients, families, staff and visitors. The facilities, equipment and maintenance staff shall be effectively managed to reduce and control hazards and risks, and prevent accidents and injuries.</i> <i>These services may be provided from within the Facility by either its own staff or contract staff, or contracted to qualified external contractors.</i>			
<u>TOPIC 3.1:</u> <u>STANDARD 3.1.1</u>	<u>ORGANISATION AND MANAGEMENT</u> <i>The Facility and Biomedical Equipment Management and Safety Services shall be organised and administered to provide optimum maintenance and safety of the Facility and equipment in support of its goals and objectives through an appointed designated Head of Service.</i>			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT
				SURVEYOR RATING
3.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Facility and Biomedical Equipment Management and Safety Services are clearly documented and measurable. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.			
	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.		
		2. Goals and objectives of the Facility and Biomedical Equipment Management and Safety Services in line with the Facility statements are available, endorsed and dated.		
		3. Evidence of planned reviews of the above statements.		
		4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)		

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.				
	Facility Comments:				
3.1.1.2 CORE	There is an organisation chart which: a) provides a clear representation of the structure, function and reporting relationships between the Head and the staff of the Facility and Biomedical Equipment Management and Safety Services; b) is accessible to all staff and clients; c) includes off-site services if applicable; d) is revised when there is a major change in any of the following: i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns.				
	EVIDENCE OF COMPLIANCE	1. Clearly delineated current organisation chart with line of functions and reporting relationships.			
		2. Organisation chart of the service is endorsed, dated and accessible.			
		3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).			
	Facility Comments:				
3.1.1.3 CORE	Where the entire Facility and Biomedical Equipment Management and Safety Services or any part of the Services has been outsourced to any external service provider(s), the Person In Charge (PIC) shall ensure that there is a written agreement between the external service provider and the Facility stating the requirements for goods and service delivery that addresses the following: a) formal lines of communication and responsibilities between the external service provider and the Facility; b) provision of adequate numbers of appropriately qualified personnel to perform their duties;				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	c) participation, as appropriate, of the external service provider in committees of the Facility; d) arrangement for adequate pickup and delivery; e) arrangements for after-hours and emergency services within agreed response time; f) contingency plans for dealing with problems in service delivery; g) adequate facilities and equipment for providing the services at the Facility and at the site of the external services; h) appropriate key performance indicators i) involvement of the external service provider in safety and quality improvement activities of the Facility, as appropriate; j) comply with the appropriate MSQH Standards of Accreditation for Facility and Biomedical Equipment Management and Safety Services.					
	EVIDENCE OF COMPLIANCE				1. The Contract Agreement between the Facility and the external service provider(s) address items (a) to (j).	
					2. Evaluation of service provider performance	
	Facility Comments:					
3.1.1.4	Regular staff meetings are held between the Head of service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Facility and Biomedical Equipment Management and Safety Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.					
EVIDENCE OF COMPLIANCE	1. Minutes are accessible, disseminated and acknowledged by the staff.					
	2. Attendance list of members with adequate representatives of the service.					
	3. Frequency of meetings as scheduled.					
	4. Discussion and resolutions are implemented. (Problems not solved to be brought forward in the next meeting until resolved).					
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
3.1.1.5	The Head of Facility and Biomedical Equipment Management and Safety Services is involved in the planning, justification and management of the budget and resource utilisation of the services.					
	EVIDENCE OF COMPLIANCE	1. Minutes of Facility-wide management meeting				
		2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service.				
		3. Approved budget and resources				
	Facility Comments:					
3.1.1.6	The Head of Facility and Biomedical Equipment Management and Safety Services is involved in the appointment and/or assignment of staff as well as endorsement of vendor.					
	EVIDENCE OF COMPLIANCE	1. Records on staff interview (if applicable)				
		2. Appointment/assignment letter of Head of Service				
		3. Job description of Head of Service				
		4. Records on staff deployment				
		5. Duty roster				
		6. Records on evaluation of vendor's performance.				
	Facility Comments:					
3.1.1.7 CORE	Appropriate statistics and records shall be maintained in relation to the provision of Facility and Biomedical Equipment Management and Safety Services and used for managing the services and patient care purposes.					
	EVIDENCE OF COMPLIANCE	1. Records are available but not limited to the following:				
		a) statistics on technical performance indicators for previous and current years;				
		b) asset register;				
		c) maintenance records for previous and current years;				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		d) accident/incident reports;				
		e) staffing number and staff profile;				
		f) staff training records.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 3.2:		HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT				
STANDARD 3.2.1		The Facility and Biomedical Equipment Management and Safety Services shall be directed by and staffed with adequate numbers of appropriately qualified and licensed personnel as required under relevant Acts, statutory regulations and standards to achieve the objectives of the services.				
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
3.2.1.1 CORE	The Head and staff of the Facility and Biomedical Equipment Management and Safety Services shall be individuals qualified by education, training, experience and certification commensurate with the requirements of the various positions.					
		1. The head of service or any management staff shall possess certified healthcare facility manager (CHFM) certification				
		2. The head of service or any management staff shall possess at least 3 years experiences in healthcare facility management				
	Facility Comments:					
3.2.1.2	The authority, responsibilities and accountabilities of the Head of Facility and Biomedical Equipment Management and Safety Services are clearly delineated and documented					
	EVIDENCE OF COMPLIANCE	1. Appointment/assignment letter for Head of Service				
		2. Description of duties and responsibilities				
	Facility Comments:					
3.2.1.3 CORE	Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the need of the services.					
	EVIDENCE OF COMPLIANCE	1. Number of staff and qualification should commensurate with workload.				
		2. Staff to have valid registration with professionals and relevant authorities bodies				
		3. Staffing pattern				
		4. Duty roster				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	5. Census and statistics				
	Facility Comments:				
3.2.1.4	There are written and dated specific job descriptions for all categories of staff that include: a) qualifications, training, experience and certification required for the position; b) lines of authority; c) accountability, functions, and responsibilities; d) reviewed when required and when there is a major change in any of the following: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations.				
	EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (d).			
		2. Job description shall include specialisation skills			
		3. Certification by relevant bodies			
		4. The job description is acknowledged by the staff and signed by the Head of Service and dated.			
	Facility Comments:				
3.2.1.5	Personnel records on training, staff development, leave and others are maintained for every staff. Note: <i>Staff personal records may be kept in Human Resource Department as per hospital policy.</i>				
	EVIDENCE OF COMPLIANCE	1. Staff personal records include:			
		a) staff biodata;			
		b) qualification and experience;			
		c) evidence of current registration;			
		d) training record;			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		e) competency record and certification from relevant bodies				
		f) leave record;				
		g) confidentiality agreement.				
	Facility Comments:					
3.2.1.6	There is a structured orientation programme where new staff are briefed on their services, operational policies and relevant aspects of the Facility to prepare them for their roles and responsibilities.					
	EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme.				
		2. Records on structured orientation programme				
		3. Orientation module				
		4. List of attendance				
	Facility Comments:					
3.2.1.7	There is evidence of training needs assessment and staff development plan which provide the knowledge and skills required for staff to maintain competency in their current positions and future advancement.					
	EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and includes various risks and gaps identified.				
		2. A staff development plan based on training needs assessment is available.				
		3. Training schedule/calendar is in place.				
		4. Training module				
	Facility Comments:					
3.2.1.8	There are continuing education activities for staff to pursue professional interests and to prepare for current and future changes in practice including requirements specific to their areas of operations, i.e. the use of appropriate personal protective equipment (PPE), safety measures in hazardous workplaces, risk identification, nosocomial infections and compliance with relevant statutory regulations.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Training calendar includes in-house/external courses/ workshop/ conferences				
		2. Contents of training programme				
		3. Staff education and development programme				
		4. Records on training attended				
		5. Specific training programme on clinical risks attended				
	Facility Comments:					
3.2.1.9	Staff receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.					
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff is completed upon probationary period and as an annual exercise.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 3.3: POLICIES AND PROCEDURES						
STANDARD 3.3.1 <i>The Head of the Facility and Biomedical Equipment Management and Safety Services shall ensure that there are appropriately documented policies and procedures that reflect current knowledge and practice for the services, and they are consistent with the objectives of the Facility and Biomedical Equipment Management and Safety Services, relevant regulations and statutory requirements.</i>						
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
3.3.1.1 CORE	There are written policies and procedures for the Facility and Biomedical Equipment Management and Safety Services which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated. There is a mechanism for and evidence of a periodic review at least once in every three years.					
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for the service.				
		2. Policies and procedures are consistent with regulatory requirements and current standard practices.				
		3. Policies and procedures are updated, endorsed and dated.				
		4. Evidence of periodic review.				
	Facility Comments:					
3.3.1.2	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved. Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.					
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.				
		2. Minutes of meeting with evidence of cross reference with other departments				
		3. Documented cross departmental policies				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
3.3.1.3	Current policies and procedures are communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings				
		2. Circulation list and acknowledgement				
	Facility Comments:					
3.3.1.4 CORE	There is evidence of compliance with policies and procedures.					
	EVIDENCE OF COMPLIANCE	1. Compliance with policies and procedures through:				
		a) interview of staff on practices;				
		b) verify with observation on practices;				
		c) results of audit on practices;				
		d) practices in line with established policies and procedures.				
	Facility Comments:					
3.3.1.5	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.					
	EVIDENCE OF COMPLIANCE	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.				
	Facility Comments:					
3.3.1.6 CORE	The policies and procedures shall include emergency and contingency plans for the following outages:					
	a) water; b) electricity; c) medical gas supply;					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS				
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING			
	d) communication system (PABX/Telephone/Nurse call system/PA system); e) internet connectivity								
	EVIDENCE OF COMPLIANCE	1. Policies and procedures for emergency response plan (ERP) that address items (a) to (d) are in place.							
		2. Contact numbers of staff in-charge/relevant authorities/vendors/suppliers is made available.							
		3. Flow chart on line of communication.							
	Facility Comments:								
3.3.1.7	A permit-to-work shall always be issued before any work is carried out for all Facilities or Mechanical and Electrical works. The purpose of such a permit is to identify the works to be carried out and to provide documentary evidence that a system is only taken back into use when all tests have been satisfactorily completed.								
	EVIDENCE OF COMPLIANCE	1. Documented permit for any Facilities/Mechanical and electrical works from the relevant authority is available if any works authorised.							
		2. All relevant tests satisfactorily done for new works.							
	Facility Comments:								

SURVEY ITEM & SELF-ASSESSMENT						
<u>TOPIC 3.4:</u>	<u>FACILITIES AND EQUIPMENT</u>					
<u>STANDARD 3.4.1</u>	<i>The Head of Facility and Biomedical Equipment Management and Safety Services shall ensure adequate facilities and equipment appropriate to the needs of the various services shall be made available to meet the goals and objectives of the Facility.</i>					
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
3.4.1.1 CORE	There are adequate and appropriate facilities and equipment with proper utilisation of space to enable staff to carry out their professional and administrative functions.					
	EVIDENCE OF COMPLIANCE	1. Adequate facilities, equipment and proper utilisation of space within the Facility for staff and outsourced service providers to carry out activities related to Facility and Biomedical Equipment Management and Safety Services:				
		a) As built drawings				
		b) Appropriate office and workshop				
		c) Appropriate equipment for repairs, testing, calibration, etc				
	Facility Comments:					
3.4.1.2	There is documented evidence that facilities and equipment in the Facility complies with relevant national/international standards and current statutory requirements.					
	EVIDENCE OF COMPLIANCE	1. As built drawings endorsed by Professional Engineers/Architect				
		2. Operation and Maintenance Manual				
		3. Evidence of compliance to standards, e.g. testing and commissioning records, asset records, log book and log sheet.				
		4. Relevant warranty certificates.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
3.4.1.3 CORE	There is evidence that the Facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order. The maintenance programme and budget are reviewed.				
	EVIDENCE OF COMPLIANCE	1. Operation and Maintenance Manual			
		2. Maintenance records			
		3. Calibration, testing and commissioning records, such as schedule, stickers, etc.			
		4. Asset register			
		5. Planned Predictive Maintenance (PdM)			
		6. Planned Preventive Maintenance (PPM) records			
		7. Planned Corrective Maintenance records			
		8. Planned Replacement Programme			
		9. Complaint records			
		10. Records on work orders			
		11. Log book and log sheet			
	Facility Comments:				
3.4.1.4	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the relevant bodies operate and maintain such equipment.				
	EVIDENCE OF COMPLIANCE	1. List of personnel authorised by the Person In Charge (PIC) to operate specialised equipment.			
		2. Letter of authorisation			
		3. Training records			
		4. Staff profile of authorised personnel			
		5. Competency assessment records			
		6. Certificate/registration of competent person as required.			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT					
TOPIC 3.5:		<u>SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES</u>			
STANDARD 3.5.1		<i>The Head of Facility and Biomedical Equipment Management and Safety Services shall ensure the provision of safe and quality performance with staff involvement in the continuous safety and performance improvement activities of the services.</i>			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
3.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Facility and Biomedical Equipment Management and Safety Services. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.				
	EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to (f)			
		2. Records on performance improvement activities			
		3. Minutes of performance improvement meetings			
		4. Quality improvement studies			
		5. Records on innovation if available			
	Facility Comments:				
3.5.1.2	The Head of Facility and Biomedical Equipment Management and Safety Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement activities to appropriate individual/personnel within the respective services.				
	EVIDENCE OF COMPLIANCE	1. Minutes of meetings			
		2. Letter of assignment of responsibilities			
		3. Job description			

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS																										
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING																									
	Facility Comments:																												
3.5.1.3	The Head of Facility and Biomedical Equipment Management and Safety Services shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility. Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.																												
	<table><tr><td rowspan="10">EVIDENCE OF COMPLIANCE</td><td colspan="2">1. System for incident reporting is in place, which include:</td></tr><tr><td>a) Training of staff</td><td></td></tr><tr><td>b) Policy on incident reporting</td><td></td></tr><tr><td>c) Methodology of incident reporting</td><td></td></tr><tr><td>d) Register/records of incidents</td><td></td></tr><tr><td>2. Completed incident reports and statistics</td><td></td></tr><tr><td>3. Root Cause Analysis</td><td></td></tr><tr><td>4. Corrective and preventive action plans</td><td></td></tr><tr><td>5. Remedial measure</td><td></td></tr><tr><td>6. Minutes of meetings</td><td></td></tr><tr><td>7. Acknowledgment by Head of Service and PIC/Hospital Director</td><td></td></tr><tr><td>8. Feedback given to staff regarding incident reporting.</td><td></td></tr></table>	EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:		a) Training of staff		b) Policy on incident reporting		c) Methodology of incident reporting		d) Register/records of incidents		2. Completed incident reports and statistics		3. Root Cause Analysis		4. Corrective and preventive action plans		5. Remedial measure		6. Minutes of meetings		7. Acknowledgment by Head of Service and PIC/Hospital Director		8. Feedback given to staff regarding incident reporting.				
EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:																												
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7. Acknowledgment by Head of Service and PIC/Hospital Director																													
8. Feedback given to staff regarding incident reporting.																													
	Facility Comments:																												
3.5.1.4 CORE	There is tracking and trending of specific performance indicators not limited to but at least three (3) of the following: a) percentage of planned preventive maintenance being done on schedule (Target: 98%) b) percentage of system/service uptime (Target: 92%) c) response time i) response time to equipment failure (BEMS)																												

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	(Target: Critical care equipment – 15 minutes Other's equipment – 2 hours) ii) response time to equipment failure (FEMS) (Target: Emergency– 15 minutes Non-emergency– 2 hours) d) repair time (Target: 7 working days)				
	EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored. 2. Records on tracking and trending analysis. 3. Remedial measures taken where appropriate			
	Facility Comments:				
3.5.1.5	Feedback on results of safety and quality activities are regularly communicated to the staff and relevant authority.				
	EVIDENCE OF COMPLIANCE	1. Monthly report to Hospital Management 2. Circulation list to Hospital Management, end user and engineering staff. 3. Evidence of feedback via communication on results of quality activities through continuing education activities/meetings. 4. Minutes of service/unit/committee meetings			
	Facility Comments:				
3.5.1.6	Appropriate documentation of safety and performance improvement activities is kept, and confidentiality is preserved.				
	EVIDENCE OF COMPLIANCE	1. Documentations on performance improvement activities and performance indicators. 2. Policy statement on anonymity on patients and providers involved in performance improvement activities.			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
3.5.1.7 CORE	There are safety and performance improvement activities that address staff safety of the outsourced service providers.					
	EVIDENCE OF COMPLIANCE	1. Staff health screening				
		2. Identification of health risk factors				
		3. Infectious diseases prevention programme/activities				
		4. Anti-smoking programme				
		5. Healthy life style campaign				
		6. Staff training on:				
		a) sharps and needle stick injury management ;				
		b) occupational Safety and Health;				
		c) ergonomics;				
		d) biohazard waste disposal.				
		7. Medical check-up record.				
		8. Post exposure management				
		9. Universal/standard precautions				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT								
<u>TOPIC 3.6:</u>	<u>SPECIAL REQUIREMENTS</u>							
<u>STANDARD 3.6.1</u>	<u>BIOMEDICAL EQUIPMENT MANAGEMENT</u> <i>The Facility is equipped with safe and functional medical equipment; operated and maintained in a manner that supports the patient care objectives and compliance with regulatory requirements and safety of patients and staff.</i>							
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS				
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING			
3.6.1.1 CORE	All biomedical equipment shall comply with Medical Device Act 2012(Act 737), Atomic Energy Licensing Act 1984 (Act 304) and other applicable Act(s) for specific medical devices; the Medical Device Regulations and other applicable Regulations for specific medical device and associated Guidelines, and MS 2058, where applicable.							
	EVIDENCE OF COMPLIANCE	1. Relevant documents pertaining to Medical Device Act 2012 and MS2058 are available.						
		2. Evidence of medical devices/equipment procured from licensed establishment						
		3. Medical device registration certificate from Medical Device Authority.						
	Facility Comments:							
3.6.1.2	Life cycle costs and utilisation of biomedical equipment are reviewed and recommendations made inclusive of equipment categorised as Beyond Economic Repair (BER).Equipment are upgraded and replaced in accordance with relevant statutory regulations.							
	EVIDENCE OF COMPLIANCE	1. Records on Life Cycle Cost Analysis (LCC) programme						
		2. Upgrading and replacement of biomedical equipment comply with statutory regulations as evidenced per records.						
	Facility Comments:							

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
3.6.1.3	Operational and service manuals for biomedical equipment are current and accessible.					
	EVIDENCE OF COMPLIANCE	1. Operation and service manuals for biomedical equipment are available, appropriate and related to the services.				
	Facility Comments:					
3.6.1.4	New biomedical equipment are checked for compliance with established standards prior to use.					
	EVIDENCE OF COMPLIANCE	1. Operation and service manual is available				
		2. Safety and performance test result.				
		3. Records on testing and commissioning				
		4. The terms of warranty is managed				
	Facility Comments:					
3.6.1.5 CORE	An asset register on biomedical equipment is maintained.					
	EVIDENCE OF COMPLIANCE	1. Asset register is available and maintained.				
	Facility Comments:					
3.6.1.6 CORE	There is a comprehensive planned maintenance programme including the following documentation: a) assets register; b) work schedule system; c) schedules and records on maintenance inspections; d) supervision of service contracts; e) proper calibration of test equipment as evidenced by certification.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Documented planned maintenance programme is available and addresses items (a) to (e).				
		2. The planned maintenance programme schedule follows the manufacturer/suppliers' specifications and/or relevant authorities' regulation.				
		3. Completed planned preventive maintenance service checklist/report				
		4. Test equipment calibration report certified by accredited 3 rd party or manufacturer.				
		5. Vendors approved by relevant authorities.				
	Facility Comments:					
3.6.1.7	Medical equipment breakdown repairs shall be recorded, prioritised and if parts required it shall be use genuine parts; repaired by competent personnel. Upon completion of repair; performance test and electrical safety test to be performed (if required).					
	EVIDENCE OF COMPLIANCE	1. Repair service log				
		2. Repair service reports				
		3. Spare part list				
	Facility Comments:					
3.6.1.8 CORE	Relevant licenses/certificates of fitness are acquired and kept current as required.					
	EVIDENCE OF COMPLIANCE	1. All licences/certificates for equipment are current and complied with.				
		2. Equipment used for Radiology/Diagnostic Imaging, Medical Laboratory and Nuclear Medicine have certifications from relevant agencies/authorities for operations.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
3.6.1.9	The medical device shall only be used if it is: a) safe and efficacious. b) used in accordance with its intended purpose. c) used in accordance with manufacturer's instructions. d) properly installed, tested, commissioned, maintained, and disposed by qualified and competent person.			
	EVIDENCE OF COMPLIANCE			
	1. Operation Manual is available.			
	2. Equipment is safe and used as per manufacturer's instructions.			
	3. Testing and Commissioning record is available.			
	4. Calibration records are available.			
	5. Certificate of staff competency, e.g. registration with Medical Device Authority is available.			
	Facility Comments:			
3.6.1.10	The facility take the medical device out of operation when it is no longer safe and effective for use shall not be used and must be taken out from facility and store in appropriate place. A medical device shall be condemned or decommission if: a) BER b) Obsolete c) Unavailability of spare part in the market			
	EVIDENCE OF COMPLIANCE			
	1. Condition appraisal by qualified biomedical engineer/ vendor			
	2. Recommendation from users and/or technical experts on the ineffectiveness of any medical device.			
	Facility Comments:			
3.6.1.11	A medical device which has been taken out of operation shall be removed and disposed of in a safe manner which eliminates or reduces any of the following: a) danger and injury; b) danger of contamination with biological material or other contaminants; c) danger of environment damage; d) danger of it being re-used.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Plan/Programme for disposal of equipment is available.				
		2. Contractor/vendor for disposal programme is qualified and competent.				
		3. Disposal of radioactive related equipment comply with relevant agency/local authority requirement. i.e. Department of Environment (DOE), Atomic Energy Licensing Board (AELB)				
		4. Disposal records				
	Facility Comments:					
3.6.1.12	The Biomedical Engineering Service shall assist the Facility with the planning and inclusion of new medical equipment and replacement of existing equipment.					
	EVIDENCE OF COMPLIANCE	1. Records on advice/consultation between the Facility Management and the Biomedical Engineering Services.				
		2. Inventory list of new and replaced biomedical equipment.				
	Facility Comments:					
3.6.1.13	The performance of the medical equipment management program shall be monitored and evaluated periodically using a combination of indicators and audits, with the purpose of finding opportunities for continual improvement. Continual improvement projects shall be implemented and their results evaluated.					
	EVIDENCE OF COMPLIANCE	1. Annual Medical Equipment Management Programme Performance Evaluation Report				
		2. Records on performance indicators and audits				
		3. Continual improvement project record/report				
	Facility Comments:					
3.6.1.14	Action taken on field safety notice (FSN)/field safety corrective action (FSCA)/recall issued if any by Medical Device Authority or manufacturer and documented.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	EVIDENCE OF COMPLIANCE	1. Recall notice if any and evidence of compliance						
		2. Action taken on safety notice issued by any authority						
	Facility Comments:							
3.6.1.15	The medical equipment has to be decontaminated before being sent to the biomedical workshop. (Refer to PCI Standard)							
	Biomedical workshop shall be equipped with cleaning area.							
	EVIDENCE OF COMPLIANCE	1. Designated area for cleaning within the biomedical equipment workshop.						
		2. Procedure for cleaning in place and being practiced.						
	Facility Comments:							

SURVEY ITEM & SELF-ASSESSMENT				
STANDARD 3.6.2	<u>FACILITY MANAGEMENT</u> <i>The Facility is constructed, equipped, operated and maintained in a manner that supports the patient care objectives and the safety and comfort of patients, staff and visitors.</i>			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT
				SURVEYOR RATING
3.6.2.1 CORE	All facilities including motor vehicles should be subjected to scheduled maintenance programme and should be under the responsibility of the respective Facility Management irrespective of whether or not a full preventive maintenance scheme is being implemented in the hospital as a whole.			
	EVIDENCE OF COMPLIANCE	1. Facility is managed by certified Healthcare Facility Manager 2. Planned Preventive Maintenance (PPM) schedule (Plan and Actual) 3. Contract agreements for outsourced services 4. Job Sheet/Maintenance report		
	Facility Comments:			
3.6.2.2	The Head of the Facility Management is responsible for ensuring that the person working on any facilities and equipment are appropriately trained and qualified to carry out the work.			
	EVIDENCE OF COMPLIANCE	1. Competent person with qualification and certification from relevant authority works on designated facilities and equipment e.g., lifts, medical gas, ACMV, charginan		
	Facility Comments:			
3.6.2.3	The healthcare and related facilities shall request for competency training from approved manufacturer or approved 3 rd party training centre.			
	EVIDENCE OF COMPLIANCE	1. Records on request for competency training programme 2. Attendance list and training records 3. Training certificate must be verified and endorsed by 3 rd party.		
	Facility Comments:			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
3.6.2.4	The service provider shall provide all appropriate tests equipment. The test equipment shall be calibrated in accordance with the manufacturer's recommendations.					
	EVIDENCE OF COMPLIANCE	1. Availability of appropriate tests equipment				
		2. Validity of calibration certificate				
	Facility Comments:					
3.6.2.5	A record of the service/repair done should be kept. All the inspections and maintenance reports shall be recorded, documented and stored.					
	EVIDENCE OF COMPLIANCE	1. Maintenance and inspection records history.				
		Facility Comments:				
	3.6.2.6	Life cycle costs and utilisation of buildings and plants are reviewed and recommendations made. Building and facilities are upgraded and replaced in accordance with relevant statutory regulations.				
EVIDENCE OF COMPLIANCE		1. Records of building facilities inspections with the Life Cycle Cost Analysis (LCC) programme on facilities				
		2. Records on upgrading and replacement of the building facilities comply with statutory regulations.				
Facility Comments:						
3.6.2.7	Drawings and operational manuals for plants and equipment are current and accessible.					
	EVIDENCE OF COMPLIANCE	1. Drawings and operation manuals for plants and equipment for related services are:				
		a) available;				
		b) properly kept.				
		2. Drawings are endorsed by Professional Engineer				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
3.6.2.8	New/replaced plants and equipment are checked for compliance with established standards prior to use.				
EVIDENCE OF COMPLIANCE	1. Verification plant room area				
	2. Compliance of plants and equipment with relevant standards and regulations				
	3. Record in asset registration				
	4. Safety and performance test result				
Facility Comments:					
3.6.2.9	An asset register of plants and equipment is maintained.				
EVIDENCE OF COMPLIANCE	1. Asset register is maintained				
Facility Comments:					
3.6.2.10	There is a comprehensive planned maintenance programme including the following documentation: a) assets register. b) work schedule system. c) schedules and records on maintenance inspections. d) record of inspections of statutory equipment. e) supervision of service contracts. f) proper calibration of the testing and measurement tool by certified calibration laboratories as evidenced by certification.				
EVIDENCE OF COMPLIANCE	1. Documented maintenance programme is available.				
	2. The maintenance schedule follows the manufacturer/suppliers' specifications and/or relevant authorities' regulation.				
	3. The calibration report of test tool to be conducted by certified calibration laboratories.				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	Facility Comments:				
3.6.2.11 CORE	Relevant licences/certificates of fitness are acquired and kept current as required (e.g., lift/ any pressured vessel according to DOSH requirements)				
	EVIDENCE OF COMPLIANCE	1. All licences/certificates should be current and complied with.			
	Facility Comments:				
3.6.2.12	Safety stores, cold rooms and plant rooms are equipped with self-closing doors or safety latches, where appropriate.				
	EVIDENCE OF COMPLIANCE	1. Installation of self-closing doors and/or safety latches for stores, cold rooms, plant rooms etc.			
	Facility Comments:				
3.6.2.13	Signs throughout the Facility are clearly displayed, and easy to follow (for example, directional and safety signs, exits, isolation areas).				
	EVIDENCE OF COMPLIANCE	1. Able to find the specific locations without asking.			
		2. Appropriate signs are available and displayed clearly.			
	Facility Comments:				
3.6.2.14	There are policies on managing motor vehicles provided for staff and patient use including requirements for proper maintenance and competency of drivers with valid licences.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Policies on the use and maintenance of motor vehicles used for staff and patients.				
		2. Validity of drivers' licences				
		3. Vehicles maintenance record				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
STANDARD 3.6.3	<u>BUILDING REQUIREMENTS</u> <i>The building requirements shall cover the following aspects of the Facility:</i> • Building- Roof Top • Ceiling Height • Entrances and Exits • Windows • Doors <i>These fixtures of the buildings in the Facility providing healthcare for inpatients and outpatients shall be designed, built and maintained as per local and national standard requirements.</i>					
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
3.6.3.1	<u>Building - Roof Top</u> There shall be absence of water ponding and plant growth on the roof top and gutters. The slab water proofing to be in good condition.					
	EVIDENCE OF COMPLIANCE	1. On-site inspection shows:				
		a) roof top has no water ponding and plant growth;				
		b) no leaks spotted from the roof.				
		2. Waterproofing warranty for flat roof				
	Facility Comments:					
3.6.3.2	<u>Ceiling Height</u> The minimum height of the ceiling shall be as stated in the relevant statutory regulations as follows: a) 2.4 metres minimum clear floor to ceiling height for air-conditioned rooms or areas. b) 3.0 metres minimum clear floor to ceiling height for non-air-conditioned rooms or areas.					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	c) 2.7 metres minimum clear floor to ceiling height in operating rooms, labour delivery rooms and similar rooms having special ceiling-mounted light fixtures.				
	EVIDENCE OF COMPLIANCE	1. Design and height of the ceiling for specific rooms/locations comply with relevant requirements as listed in (a) to (c).			
	Facility Comments:				
3.6.3.3 CORE	The ceilings in clean room areas and critical pressure controlled rooms shall be seamless type.				
	EVIDENCE OF COMPLIANCE	1. Design of the ceiling in critical areas such as isolation room, microbiology room, Sterile Store, operating theatre, Intensive Care Unit comply with specific requirements, i.e. seamless type.			
	Facility Comments:				
3.6.3.4	<u>Entrances & Exits</u> a) Entrances and exits in the Facility shall be located in an area where minimum disturbance is caused to patients. Entrance for patients and visitors of the Facility shall be adjacent to the lobby. b) There shall be at least one entrance which is designed without stairs for the movement of patients in wheelchairs or on stretcher in the Facility or service. c) There shall be separate emergency patient entrance, service entrance and patient and visitors entrance. d) Emergency patient entrance shall be located for ready access to emergency department or unit and readily accessible to pedestrian, ambulance and other vehicular traffic. e) Service entrance shall be located close to storage room or area, elevators and kitchen. f) There shall be a separate exit where dead bodies can be removed in an unobtrusive manner. g) The entrances shall be equipped with mechanism to prevent ingress of hot and humid outside air into the building to reduce any risk of surface condensation.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	EVIDENCE OF COMPLIANCE	1. Building design shows entrances and exits comply with requirements listed (a) to (f) upon inspection.					
		2. Entrances and exits to the buildings comply with the requirements of relevant authorities i.e. fire authority					
	Facility Comments:						
3.6.3.5	<u>Windows</u> Windows are required in all patient rooms except labour delivery rooms. Windows allow for unobstructed natural lights.						
EVIDENCE OF COMPLIANCE	1. Presence of windows in all patient care rooms except in Labour Delivery Suites. Verified upon inspection.						
	Facility Comments:						
3.6.3.6	<u>Doors</u> Doors to patient rooms and exit doors are not locked from the inside except where specifically required (for example, psychiatric units). In such cases, there are documented policies and procedures to ensure adequate access and egress.						
EVIDENCE OF COMPLIANCE	1. Policies and documented instructions on access and egress to patients' rooms.						
	2. Doors to patients' rooms found not locked from the inside as per policy upon inspection.						
Facility Comments:							
3.6.3.7	Patients' toilet door to be open outward but not to obstruct main corridors.						

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Patients' toilet door open outward as per regulation.	☐			
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT				
STANDARD 3.6.4	<u>EXTERNAL FACILITIES</u> <i>The external facilities of the buildings that cover the estate grounds and include parking space and internal roads shall be well maintained to provide easy and safe access and prevent potential harm from the surroundings to patients, staff and visitors to the Facility.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
3.6.4.1	The estate grounds are well maintained as follows:			
	a) road and drainages kept clean;			
	b) trees are trimmed with no potential falling branches;			
	c) drains and manholes are not clogged and properly covered.			
EVIDENCE OF COMPLIANCE	1. Visual inspection shows clean estate grounds as listed (a) to (c)			
	2. Maintenance records			
Facility Comments:				
3.6.4.2	Parking space shall be adequately provided, and properly lighted and managed.			
	1. Adequate parking space; well lighted and managed.			
	2. Maintenance records			
	3. Plan and provision to cater for insufficient parking space to patient and visitors			
EVIDENCE OF COMPLIANCE				
Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT							
STANDARD 3.6.5		<u>SEWAGE AND SEWERAGE SYSTEM</u> The management shall ensure that the sewerage system of the Healthcare Facility is uninterrupted and functional at all times and ends at the entry to a sewage treatment plant maintained by the Facility or the local authority.					
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
3.6.5.1 CORE	There shall be no exposed sewer line located directly above clinical areas, working, storing or eating surfaces in kitchens, dining rooms or areas, pantries, food storage rooms or areas or where medical or surgical supplies are prepared, processed or stored.						
	EVIDENCE OF COMPLIANCE	1. Inspection and checking of the as built drawing shows no exposed sewer lines over critical clinical and support services areas.					
	Facility Comments:						
3.6.5.2	Affluent test is to be conducted every six months.						
	EVIDENCE OF COMPLIANCE	1. Affluent test reports.					
	Facility Comments:						
3.6.5.3	There shall be a competent operator to manage the sewage treatment plant where available as required under the Drainage and Sewerage Act.						
	EVIDENCE OF COMPLIANCE	1. Compliance with National Water Services Commission (Suruhanjaya Perkhidmatan Air Negara, SPAN) regulation					
		2. The contractor doing the maintenance work is qualified and registered with SPAN.					
	Facility Comments:						

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
3.6.5.4	Water run-off from clinical and domestic waste storage area shall be connected to the sewage treatment plant (STP) of the Facility or municipal sewage treatment plant.					
	EVIDENCE OF COMPLIANCE	1. Piping system connected to STP as observed upon inspection				
		2. As built drawing of facility and piping system				
	Facility Comments:					
3.6.5.5	The Sewage System shall be properly maintained. There shall be no waste water and sewage overflow to open environment.					
	EVIDENCE OF COMPLIANCE	1. Maintenance reports on STP				
		2. Visual checking of the piping system				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT				
STANDARD 3.6.6	<u>MECHANICAL SYSTEM</u> <u>AIR CONDITIONING AND VENTILATION SYSTEM</u> <i>Air conditioning and ventilation systems installed for the purpose of patient and staff safety and comfort must take into consideration the control of airborne infections. Operating suites, nurseries, special care units, isolation rooms and laboratories shall be air-conditioned and ventilated in accordance with the requirements of the relevant Acts, statutory requirements, and local building codes.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
3.6.6.1 CORE	Air conditioning and ventilation systems installed for the purpose of patient and staff safety and comfort should take into consideration the control of airborne infections. Operating suites, nurseries, special care units, isolation rooms and laboratories shall be air-conditioned and ventilated in accordance with the requirements of the relevant Acts, statutory requirements, and local building codes.			
	EVIDENCE OF COMPLIANCE 1. Comply with the requirements of the relevant Acts, statutory requirements, and local building codes.			
	Facility Comments:			
3.6.6.2	Cooling towers associated with air conditioning systems are inspected regularly to ensure they are clean and free from algae and Legionella bacteria.			
	EVIDENCE OF COMPLIANCE 1. Records on monthly inspection of cooling towers			
	EVIDENCE OF COMPLIANCE 2. Results on test on Legionella bacteria done every six (6) months.			
	EVIDENCE OF COMPLIANCE 3. Regular water quality test results			
	Facility Comments:			
3.6.6.3	Where cooling is required for critical service areas, a backup chiller or standby unit chiller, supplied with essential electrical power supply is required.			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Evidence of standby/backup chiller as required			
		2. As built drawings			
	Facility Comments:				
3.6.6.4	The air ducts at critical areas and filters are inspected, cleaned and maintained regularly; and included in the yearly preventive maintenance programme				
	EVIDENCE OF COMPLIANCE	1. Air ducts and filters preventive maintenance programme covers:			
		a) list of critical areas;			
		b) duct inspection done yearly;			
		c) duct cleaning done when required;			
		d) filter inspection done regularly.			
		2. Maintenance records			
	Facility Comments:				
3.6.6.5	Air handling units, fan coil units, exhaust fans, and piping systems are maintained and checked regularly.				
	EVIDENCE OF COMPLIANCE	1. Maintenance records			
	Facility Comments:				
3.6.6.6	Ventilation a) All rooms and areas shall be adequately ventilated with minimum six (6) air change per hour.				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	b) The ventilation system shall be adequate to provide ten (10) air change per hour without re-circulation in areas in which excessive heat, moisture, odours or contaminants originate. c) Microbiology work rooms or areas shall not have any re-circulation of air and shall be air-conditioned. d) All fresh air supply inlets shall be so located to ensure a source of fresh air away from any source of contaminants or odours (shall be not less than 2.5m from the ground level or similar external surfaces). e) Air discharge exhaust shall be located away from air supply intakes or windows to avoid cross circulation of air (shall be not less than 2.5m from the ground level or similar external surfaces). f) The design and balancing of the ventilation system shall be such as to avoid airflow from rooms or areas likely to contain contaminants to other patient care rooms or areas, food preparation or serving rooms or areas, and rooms or areas containing clean or sterile supplies and equipment. g) Where centralised air conditioning is used, air from rooms or areas likely to contain infectious micro-organisms or noxious gas shall be exhausted to the outside and not re-circulated through the normal air conditioning system. h) Where toxic materials are used in a laboratory, the ventilation system shall be capable of removing toxic and noxious fumes and providing adequate fresh air to the laboratory. i) All air supplied to critical service areas such as operating theatres, labour-delivery rooms and nurseries shall be delivered at or near the ceiling of such room or areas served. j) The ventilation for the newborn nursery shall: i) have a minimum ventilation rate of twelve air change per hour which is provided by mechanical supply and exhaust air systems;			

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	ii) have filters with a minimum efficiency of ninety percent in the retention of particles with a pre-filter of twenty-five percent efficiency rate; iii) maintain a positive air pressure relative to the air pressure of adjacent rooms or areas. k) Operating theatres and its ancillary facility shall be: i) mechanically ventilated to provide one hundred percent fresh air without recirculation; ii) be provided with a minimum ventilation rate of twenty air change per hour by mechanical supply and exhaust air systems; iii) outdoor air intakes shall be located as far as practicable but not less than 7.6 metres from the exhausts from any ventilation system, combustion equipment, medical-surgical vacuum system or plumbing vent or areas which may collect noxious fumes. l) The ventilation for isolation room for patients with airborne infection shall be as follows: i) the air inlets should be at a high level close to the patient's head with extraction points at low level; ii) have a minimum ventilation rate of twelve air change per hour which is provided by mechanical supply and exhaust air systems; iii) maintain a negative pressure relative to air pressure of adjacent areas; iv) the air should flow from cleaner areas into isolation rooms (less clean areas) to prevent spread of contaminants to other areas; v) air from the room shall be fully exhausted to outside air through HEPA filtration. vi) Ante room shall be provided with pressure differential indicator for patient and ante room. m) The ventilation for isolation room for immunodeficiency patient shall: i) have a minimum ventilation rate of twelve air change per hour which is provided by mechanical supply and exhaust system; ii) maintain a positive pressure relative to air pressure of adjacent areas. n) In critical services areas such as operating theatres, sterile store, Central Sterilising Supply Unit, Intensive Care Unit, High Dependency Unit, Neonatal Intensive Care			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS			
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	Unit, isolation room, Special Care Nursery, Microbiology laboratory and Pharmacies, the air distribution shall be ducted type for the supply and exhaust system.						
	EVIDENCE OF COMPLIANCE	1. Annual Indoor Air Quality (IAQ) reports					
		2. Inspection of the ventilation system in the facility and compliance to requirements as listed (a) to (n)					
		3. Evidenced as per as built drawings					
	Facility Comments:						

SURVEY ITEM & SELF-ASSESSMENT					
STANDARD 3.6.7		<u>INDOOR AIR QUALITY</u> <i>The Facility implements Indoor Air Quality Programme to ensure the quality of air conforms to Ministry of Health Guidelines on Indoor Air Quality that supports the patient care objectives; and safety of patients, staff and visitors.</i>			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
3.6.7.1	<u>Indoor Air Quality (IAQ)</u> Head of the Facility Management shall ensure optimal Indoor Air Quality (IAQ) as follows: a) establish documented strategies, objectives and plans to effectively manage IAQ; b) implement and monitor regularly Indoor Air Quality (IAQ) in identified areas in the hospitals; c) plan and conduct yearly audits for compliance with performance standards and requirements. d) Perform remediation actions on identified indoor air quality and indoor surface condensation issues.				
	EVIDENCE OF COMPLIANCE	1. Annual Monitoring/mapping IAQ report is available			
		2. Audit report on compliance to performance standards is available.			
		3. No visible fungal or mould growth seen especially at critical patient care areas and indoor surfaces.			
Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT											
STANDARD 3.6.8	<u>MEDICAL GASES</u> <i>Medical gas supply includes delivery of oxygen, nitrous oxide, active anaesthetic gas scavenging system (AGSS), medical/ surgical air, vacuum system etc either by cylinders or piped to various parts of the healthcare facility. There is evidence that the healthcare facility has documented procedures and practice good management to ensure that medical gas supply is supplied and delivered in a clean, safe and reliable manner.</i> <i>The safety of all Medical Gas System is dependent on four (4) basic tenets:</i> <i>a) identification;</i> <i>b) adequacy;</i> <i>c) continuity;</i> <i>d) quality of supply.</i>										
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS								
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING							
3.6.8.1	<u>Standard compliance</u> Medical Gas System (MGS) installation shall comply with Medical Device Act (MDA) (Act 737), Private Healthcare Facilities and Services (PHFS) Act, MS 2675-1..2017 and relevant Malaysian/international standards. All installation, construction, testing and commissioning, operation and maintenance of the system shall be done by competent persons, supervised by an Authorised Person and approved by relevant authorities.										
	<table><tr><td rowspan="3">EVIDENCE OF COMPLIANCE</td><td>1. As Built Drawing of the system certified by Authorised Engineer/Professional Engineer</td><td></td></tr><tr><td>2. Testing and commissioning report witnessed by competent person.</td><td></td></tr><tr><td>3. Department of Occupational Safety and Health (DOSH) PMT certificates</td><td></td></tr></table>	EVIDENCE OF COMPLIANCE	1. As Built Drawing of the system certified by Authorised Engineer/Professional Engineer		2. Testing and commissioning report witnessed by competent person.		3. Department of Occupational Safety and Health (DOSH) PMT certificates				
EVIDENCE OF COMPLIANCE	1. As Built Drawing of the system certified by Authorised Engineer/Professional Engineer										
	2. Testing and commissioning report witnessed by competent person.										
	3. Department of Occupational Safety and Health (DOSH) PMT certificates										
	Facility Comments:										
3.6.8.2 CORE	<u>Competencies</u> All staff handling Medical Gas System (MGS) has to be competent. There is an Authorised Person to manage and supervise the medical gasses operations and maintenance. Regular training to be done according to the standards requirements for all staff handling medical gas.										

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Competency Certificate of Competent Person and Authorised Person				
		2. Staff training records				
	Facility Comments:					
3.6.8.3	Plant Room MGS Plant/Manifold/Storage Rooms shall be dedicated and no other materials are allowed in these rooms. It shall be ventilated, properly labelled for each system and with easy excess for cylinder delivery. These rooms shall be secured, clean and weather proofed. All cylinders shall be secured.					
	EVIDENCE OF COMPLIANCE	1. Compliance to standard requirements of MGS plant room				
		2. Verification upon inspection				
	Facility Comments:					
3.6.8.4	Fire Precautions Smoke or heat detector heads shall be installed in the plant rooms/medical gases manifold rooms and medical gases cylinder stores in (when inside) any facility.					
	EVIDENCE OF COMPLIANCE	1. As built drawings				
		2. Verification on inspection				
	Facility Comments:					
3.6.8.5	Electrical Precautions The electricity supply to medical gas installations/plant/manifold shall be taken from separate circuits from a distribution board which is an "essential" board fed by the emergency generator system. The manifolds to be connected with unswitched fused spur.					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. As built drawing			
		2. Verification on inspection			
	Facility Comments:				
3.6.8.6	Identification a) All pipe needs to have proper labelling of specific gas, colour coded with directional flow. b) All valves need to be labelled and an indication of which area they are serving. The index shall be placed in an area which is accessible to maintenance staff or the staff in-charge of that area. c) Plant/Manifold Rooms needs to be labelled with No Parking signs, Each Service of Gases: Primary, Emergency Standby and Storage of Cylinders. Cylinder stores MUST clearly label empty cylinder and full cylinder areas. d) Riser and access to high level ball valves needs to be identified. e) Ward cylinder storage area needs to be identified and also properly secured. f) The cylinders valves to be pin index type.				
	EVIDENCE OF COMPLIANCE	1. Verification on medical gas safety requirements as listed (a) to (f) through site inspection.			
	Facility Comments:				
3.6.8.7	Source of Supply (Adequacy & Continuity) Manifold System Oxygen, Medical Air, Nitrous Oxide and Entonox supply should consist of PRIMARY Source, EMERGENCY Standby Source and a STORAGE Source of Supply as follows: a) the primary source can be made up of two automatic gas manifolds. The gas manifold storage is usually provided on the basis of one week's supply; each bank of the manifold shall hold not less than two days' supply and a supply for three days shall be held in cylinders in the store. The primary system shall change over automatically from bank to bank;				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	b) all change of cylinders shall be logged in a log book. If each bank change is less than two days for a bank of cylinders then provision to increase the number of cylinders shall be done; c) Bulk Liquefied Oxygen (VIE Tank) for oxygen can be used when the PRIMARY manifold size is 10 cylinders on each banks; d) medical air can be supplied by oil free compressor plant when the cylinders need to be frequently changed; e) additionally an emergency standby source manifold with sufficient connected capacity to supply the pipeline for at least four hours.			
	EVIDENCE OF COMPLIANCE 1. Verification on inspection that Medical Gas Plant System (MGPS) consists of PRIMARY Source, EMERGENCY Standby Source and a STORAGE Source of Supply.			
	2. Calculation of gas supply consumption and adequacy by Authorised Person/ Professional engineer.			
	3. Emergency Standby Source functionality is regularly tested and the valves are open.			
	4. There is a test point to check the quality of gas.			
	Facility Comments:			
3.6.8.8	Vacuum Insulated Evaporator (VIE) System for Oxygen The liquid oxygen vessel is normally selected to provide for at least 14 days' consumption or subjected to risk assessment by an Authorised Person/ Professional engineer, Suppliers and Management. An emergency back-up supply equivalent to 24 hours average use shall be available on site. This may be provided by bulk liquid or oxygen cylinders as appropriate for each site. There has to be a performance contract with the gas supplier to ensure continuous supply including emergency usage.			
	EVIDENCE OF COMPLIANCE 1. Calculation on oxygen usage report			
	2. Risk assessment report			
	3. Maintenance record			
	Facility Comments:			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
3.6.8.9	The VIE vessel shall be approved by Department of Occupational Safety and Health (DOSH).					
	EVIDENCE OF COMPLIANCE	1. PMT certificate				
	Facility Comments:					
3.6.8.10	The VIE tanks shall be fenced off. Adequate warning signage shall be posted on the fence. No vehicle or unsafe activities to be done within the safe distance as per Malaysian Standard on Medical Gas Piping System guidelines.					
	EVIDENCE OF COMPLIANCE	1. Site inspection on compliance with Malaysian Standard on Medical Gas Piping System guidelines.				
	Facility Comments:					
3.6.8.11	Where consumption of gas is low or the use is only for specific location, e.g. for surgical air, entonox or carbon dioxide etc than PRIMARY gas manifold source and a STORAGE source of supply is allowed.					
	EVIDENCE OF COMPLIANCE	1. As built drawing				
		2. Verification on inspection				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
3.6.8.12 CORE	<u>Plant Monitoring System</u> A 24 hours Medical Gas monitoring Alarm Panel needs to be installed at the manned staff area. (e.g. control room). It will send a warning signal for any fault from the plant or user areas i.e. Low flow or Low Pressure. There are regular tests of the functionality of the alarm system.					
	EVIDENCE OF COMPLIANCE				1. Records on testing of the alarm system.	
					2. Verification on inspection of the Medical Gas monitoring Alarm Panel.	
	Facility Comments:					
3.6.8.13	<u>Quality</u> a) The supplier of medical gas shall ensure the quality of medical gas supply complies with the national or appropriate sections of the current edition international standard b) There is record of commissioning and testing of all medical gas piping systems for new and retrofit installation c) Additional quality test may be conducted whenever there is a concern on gas quality.					
	EVIDENCE OF COMPLIANCE				1. Latest quality certificates of the medical gas supplier.	
					2. Commissioning and testing reports	
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT				
STANDARD 3.6.9	<u>MEDICAL AIR SYSTEM</u> <i>Medical Air Supply is an integral part of a patient's life support system. As such, each component must be carefully designed to ensure the air purity and operational reliability required.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
3.6.9.1 CORE	Medical Air supply ensures:			
	a)medical air is supplied at a pressure of 400kPa required to drive ventilators and for other respiratory applications.			
	b)surgical air is supplied at a pressure of 700kPa or higher for surgical air to drive surgical tools.			
	c)the medical air system shall have minimum Duplex System with Emergency Standby Manifold from oil free compressors.			
	d)medical air supply design must ensure air purity and operational reliability			
EVIDENCE OF COMPLIANCE	1. Verification upon inspection			
	2. PMT certificate			
	3. As Built Drawing to be endorsed by professional engineer			
Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT											
STANDARD 3.6.10	<u>VACUUM SYSTEM</u> <i>The vacuum system is an integral part of the patient's life support system. The Healthcare Facility has documented procedures and practice good management to ensure that the vacuum system is clean, safe and reliable.</i>										
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS								
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING							
3.6.10.1	The vacuum system is normally supplied at 40kPa at the terminal unit used via a suction control device and fluid is collected in suction jars. Typically the duplex system is installed and adequate number of outlets is available at the patient areas. The exhaust shall be away from any air intake, windows or air compressor intake. There is a record of regular replacement of bacterial filter.										
	<table><tr><td rowspan="3">EVIDENCE OF COMPLIANCE</td><td>1. Verification on inspection</td><td></td></tr><tr><td>2. Records on regular replacement of filters to the suctions</td><td></td></tr><tr><td></td><td></td></tr></table>				EVIDENCE OF COMPLIANCE	1. Verification on inspection		2. Records on regular replacement of filters to the suctions			
EVIDENCE OF COMPLIANCE	1. Verification on inspection										
	2. Records on regular replacement of filters to the suctions										
	Facility Comments:										

SURVEY ITEM & SELF-ASSESSMENT						
STANDARD <u>3.6.11</u>	<u>ACTIVE ANAESTHETIC GAS SCAVENGING SYSTEM</u> <i>There is evidence that the Healthcare Facility has documented procedures and practice good management to ensure that AGSS is made available wherever nitrous oxide is administered.</i> <i>Active Anaesthetic Gas Scavenging Systems (AGSS) enhances the safety of the environment in which members of the staff are in close proximity with waste anaesthetic gas.</i>					
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT		
				SURVEYOR RATING		
3.6.11.1	The number of disposal system pumps should match the number of Air Handling Unit (AHU) installed in the area required. Wherever Nitrous Oxide is administered, an Anaesthetic Gas Scavenging System (AGSS) shall be made available.					
	EVIDENCE OF COMPLIANCE	1. As built drawing				
		2. Verification on inspection				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT				
STANDARD 3.6.12	<u>VERTICAL TRANSPORT SYSTEM</u> <i>Vertical Transport System covers any equipment that transports passengers and goods vertically such as lifts, escalators, dumbwaiters, suspended platform etc. Pneumatic tube system is also part of the transport system.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
3.6.12.1 CORE	a) There is a certificate of fitness to verify that elevators comply with requirements of the Department of Occupational Safety and Health. b) The number and size of the elevators comply with the requirements of the Private Healthcare Facilities and Services Act (PHFSA) 1998 and Regulations 2006 that covers the following: i) its use to facilitate hospital operation features; ii) lifts shall be provided with Automatic Rescue Devices (ARD), Emergency Battery Operated Power (EBOP) and Car Locking Devices; iii) for patient transportation, the size of such elevator is at least to be 1.5 metres by 2.1 metres clear size with a capacity of 1,500 kilograms, car and shaft doors of at least 1.2 metres clear opening; iv) for transfer of patient-bed with attachments, the size of such elevators are appropriate to such function.			
	EVIDENCE OF COMPLIANCE	1. Valid and current certificate of fitness		
		2. Yearly licence by Department of Occupational Safety and Health (DOSH)		
		3. The design, size and specification of lift comply with Private Healthcare Facilities and Services Act 1998, and Regulations 2006.		
		4. Verification of lift Operation and Maintenance (O&M) and lift drawing endorsed by manufacturer, Professional Mechanical Engineers and inspected by Department of Occupational Safety and Health (DOSH).		

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		5. Records on maintenance and inspection				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
STANDARD 3.6.13	WATER SUPPLY Clean and potable water shall be available in sufficient quantity for the operations of the Facility for patient care, staff and visitors.					
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
3.6.13.1 CORE	There is evidence that water supply is microbiologically tested periodically and treated as necessary. The Facility shall obtain the water quality report for water supplied directly from a public water service provider.					
	EVIDENCE OF COMPLIANCE	1. Minimum storage of 48 hours water supply.				
		2. Verification of as built drawing for cold water system for kitchen, suction tank, storage tank				
	Facility Comments:					
3.6.13.2	The Facility water supply complies with the World Health Organization (WHO) water quality standards and guidelines and tested by certified laboratory.					
	EVIDENCE OF COMPLIANCE	1. Results of water sampling test from the approved body				
	Facility Comments:					
3.6.13.3	The Facility's water supply system shall not be connected with other piping systems or with a fixture that could allow contamination of the water supply. Water to kitchen and food preparation areas shall be directly from main supply.					
	EVIDENCE OF COMPLIANCE	1. Visual check on the piping system				
		2. Hot and cold water piping as built drawings endorsed by Professional Engineer.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS			
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
3.6.13.4	Drinking water storage tanks (if available) are secured and inspected monthly to ensure they are safe and free from algae. The water shall be maintained at a microbiologically accepted standard. Water analysis for drinking water shall be done at least once yearly to acceptable standard (e.g. World Health Organization, WHO).						
	EVIDENCE OF COMPLIANCE	1. Maintenance reports on water storage tanks, i.e.log book on inspection					
		2. Report on the cleaning of storage and suction tanks					
		3. Reports on water analysis					
	Facility Comments:						

SURVEY ITEM & SELF-ASSESSMENT					
STANDARD <u>3.6.14</u>	<u>ELECTRICAL SYSTEM – GENERAL COMPLIANCE</u> <i>The general compliance to the electrical system covers the following aspects in the Facility:</i> • <i>Electrical Supply</i> • <i>Electrical Distribution Scheme</i> • <i>Electrical Standby Generator</i> • <i>Uninterrupted Power Supply System (UPS)</i> • <i>Illuminations and Light Fittings</i> • <i>Switch Socket Outlets</i> <i>The electrical system of the Healthcare Facility shall be adequately sized and comply to Act 586 and MS IEC 60364 to cater for the services requirements.</i>				
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
3.6.14.1	<u>Electrical Supply</u> Electrical supply to the healthcare facilities shall be adequately sized to cater for the services' requirements that include provision for emergency supply and uninterrupted power supply. The installation and operation of electrical system shall meet with regulatory requirements				
	EVIDENCE OF COMPLIANCE	1. As Built Drawings on the electrical system			
		2. Appointment of Competent Electrical Engineers, charge-man, wiremen			
		3. Letter of appointment and credentials of electrical engineer and charge-man including competent personnel certification from National Energy Commission			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
3.6.14.2	<u>Electrical Distribution Scheme</u> Normal, essential and uninterrupted power supply shall be provided in hospital facilities accordance to requirement and criticality of service requirement.			
	EVIDENCE OF COMPLIANCE			
	1. Verification of evidence as endorsed from as built drawings.			
	2. Electrical single line diagram endorsed by Professional Engineer.			
	Facility Comments:			
3.6.14.3 CORE	<u>Electrical Standby Generator</u> a) Adequate emergency electrical generator with automatic transfer in case of interruption of normal power supply shall be provided to the following essential systems, equipment, rooms or areas: i) Public Address System/Fireman Evacuation Announcement System; ii) Nurse Call System; iii) Alarm System; iv) Piped Medical Gas System; v) Equipment necessary for maintaining telephone service (PABX); vi) Fire lift; vii) Fire pumps; viii) selected sockets in the vicinity of emergency electrical generating equipment; ix) selected areas in nurseries, critical care units, intensive care units, cardiac care units, exhaust systems at isolation rooms, operating theatres, labour-delivery rooms, emergency rooms, recovery rooms, laboratory, blood bank locations, medicine dispensing areas, radiology and radiographic rooms, mortuary freezers. x) Air conditioning system in critical service areas. b) The generator-set fuel storage shall be able to provide backup power supply in the event of power failure for at least eight (8) hours.			

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	c) The emergency power shall be in operation within the stipulated time after interruption of normal power supply. d) Emergency power supply shall also be provided for the illumination of: i) exit signs, exit directional signs and staircases; ii) nurses' stations; iii) corridors in patient care rooms or areas and patient toilets; iv) vicinity of electrical generating equipment. e) The generator installation shall have proper acoustic treatment to meet the regulations by the Department of Environment, i.e. Sound Level must be less than 85 dB. f) Electrical generator shall be operated for a minimum of thirty minutes weekly or as stipulated by the manufacturer including a monthly test under "load" condition and proper record of tests shall be maintained.			
	EVIDENCE OF COMPLIANCE			
	1. Evidence of emergency electrical generator supply for services listed in (a)(i) to (x)			
	2. Dedicated electrical board for emergency power supply is available and clearly labelled.			
	3. The switched-socket outlet is red-coloured rocker.			
	4. Endorsed as built drawings of emergency power supply			
	5. Relevant test reports			
	6. Test report for eight (8) hours consumption.			
	7. Evidenced as in endorsed as built drawings.			
	8. Verification as evidenced through inspection			
	9. As built drawings			
	10. Verification by inspection			
	11. Relevant test reports			
	Facility Comments:			
3.6.14.4 CORE	<u>Uninterrupted Power Supply System (UPS)</u> a) Uninterrupted power supply (UPS) shall be provided for life support systems, essential lights in operating theatres and rooms for interventional procedures.			

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	b) UPS system in operating theatres shall be provided with an alarm system at the reception counter and control room which will be triggered when the system is not charged.					
	c) Adequate UPS also shall be provided to the following: i) Public Address/Fireman Evacuation Announcement System ii) Nurse Call System iii) IT server room					
	EVIDENCE OF COMPLIANCE				1. Endorsed as built drawing i.e. for UPS and power supply for Nurse Call system	
	2. Periodic maintenance records					
	3. Verification through actual site inspection.					
	Facility Comments:					
3.6.14.5	<u>Illuminations and Light Fittings</u> a) The level of illuminations shall meet the MS 1525. b) Bedhead lamp shall be located at each bed. c) There shall be adequate lighting in patient toilet room with adequate back-up by emergency power supply for the light fitting. d) Night light shall be properly located in each patient room and at proper intervals in corridors in nursing unit. e) Switches for night lights and general illumination shall be adjacent to doors to patient rooms; except for psychiatric patient; the switches shall be placed outside of the rooms.					
EVIDENCE OF COMPLIANCE	1. Lighted areas and level illuminations meet MS 1525					
2. Energy audit reports						
3. Evidence through actual site inspection						
4. Endorsed as built drawings.						
Facility Comments:						

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
3.6.14.6	Switch Socket Outlets a) <u>Nature of electrical sockets.</u> The type, quantity, location and height of electrical sockets shall be appropriate for the services to be performed and all sockets shall be of the grounding type as per National Energy Commission requirements. There shall be compliance with electrical standards for cardiac-protected or body-protected electrical areas in the operating rooms, interventional cardiology laboratory and critical care units. b) Switch socket outlets shall be differentiated between normal, uninterrupted power supply (UPS) and emergency power supply and coded according to international standards. Notes/Explanations: International colour codes for switch socket outlets: • normal local supply – white; • uninterrupted power supply (UPS) – yellow; • emergency power supply (EPS) – red. c) There shall be adequate number of electrical sockets connected to an emergency power source: - located in operating theatres, nursery, labour-delivery rooms, emergency room and all intensive care units suitable for the services to be performed; - located at the head of each bed in patient rooms, labour-delivery rooms, recovery rooms and all intensive care units; - in all nursing units; - for critically needed equipment in all patient care areas; - for refrigerators for biologicals; - for x-ray illuminators in each operating theatre room and emergency room; - The sockets shall not be used other than for patient care purposes.			
EVIDENCE OF COMPLIANCE	1. Electrical sockets in the facility cover all aspects listed in (a) to (c)			
	2. Endorsed as built drawings.			
	3. Evidence through actual site inspection.			
Facility Comments:				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS			
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
3.6.14.7	Voltage stabilisers shall be provided in areas where high precision equipment is located.						
	EVIDENCE OF COMPLIANCE	1. Voltage stabilisers available where required					
		2. Endorsed as built drawings.					
		3. Evidenced through actual site inspection.					
	Facility Comments:						
3.6.14.8	Surge protection devices (SPDs) shall be provided for the main electrical distribution system including sub-switchboards and distribution boards, computers, electronic equipment, etc. which are susceptible to lightning and switching surges; in adequate quantity.						
	EVIDENCE OF COMPLIANCE	1. Surge protection devices available where required					
		2. Evidenced through actual site inspection.					
	Facility Comments:						
3.6.14.9	<u>Use of Telecommunication Device</u> a) The use of telecommunication devices shall not be permitted within critical care units, operating theatre and any other room or area where the use of telecommunication device will disrupt the proper functioning of any equipment in the room or area. b) The signage relating to the prohibition of the use of telecommunication device shall be prominently displayed and strictly adhered to.						
	EVIDENCE OF COMPLIANCE	1. Policy on the use of telecommunication device.					
		2. Signage on the prohibition of use of telecommunication device.					
	Facility Comments:						

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
3.6.14.10 CORE	<u>Maintenance</u> a) Frequency and maintenance procedure shall be according to the Operation Manual and Maintenance (O&M) from the original manufacturer of the equipment or under the regulatory requirements. b) All maintenance and calibration work shall be carried out by the competent person mentioned as per regulatory requirements. c) Electrical substations, rooms and distribution board to be secured and can only be accessed by authorised personnel.				
	EVIDENCE OF COMPLIANCE	1. Scheduled maintenance shall follow recommendation from manufacturer/supplier/installer.			
		2. Records on maintenance and evidenced through as built drawings			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT					
STANDARD 3.6.15	<u>ELECTRICAL SYSTEM FOR CRITICAL AREAS</u> <i>The electrical system for critical areas cover as follows but not limited to:</i> 1. Operation Theatres 2. Critical Care Area (Intensive Care Unit, High Dependency Unit, Cardiothoracic Intensive Care Unit, Cardiology Care Unit, NICU & PICU) 3. Isolation Room 4. Central Sterile Supply Department 5. IT Server Rooms 6. Microbiology laboratory 7. Blood Bank				
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
3.6.15.1 CORE	Isolated Power Supply System (IPS) [for operating theatres, critical care area] is designed that: a) The department shall be facilitated with adequate Insulation Monitoring Device (IMD) OR Line Isolation and Overload Monitoring Device (LIOM) an integral part of Isolated Power Supply System (IPS). b) The system shall be used and maintained properly with proper documentation.				
	EVIDENCE OF COMPLIANCE	1. Endorsed as built drawing.			
		2.Periodic maintenance records			
		3. Evidenced upon actual site inspection			
	Facility Comments:				
3.6.15.2	Uninterruptible Power Supply System (UPS) [for operating theatres, critical care area] is designed that: a) Uninterruptible power supply system shall be provided for life support system, essential lights in the operation theatres and rooms for interventional procedure.				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	b) The UPS, including the battery, shall be of sufficient capacity for the present loads. The battery capacity shall be not less than one (1) hour at the capacity of the UPS, including future extension.					
	c) UPS system in operating theatres shall be provided with an alarm system at the reception counter and control room which will be triggered when the system is not charged;					
	d) A UPS shall also be provided for Nurse Call System.					
	EVIDENCE OF COMPLIANCE				1. UPS is provided in operating theatre and critical care areas and covers all aspects as listed (a) to (d).	
	2. Endorsed as built drawing, i.e. for UPS and for nurse call power supply.					
	3. Periodic maintenance records					
	4. Evidenced through actual site inspection					
	Facility Comments:					
3.6.15.3	Electrical Standby Generator Set [for operating theatres, critical care area, isolation rooms, Central Sterile Supply Department, Sterile Store] is designed that:					
	a) These areas shall have adequate emergency electrical standby generator power supply which is equipped with automatic transfer switch (ATS) in case of power supply interruption for selected power socket outlets, lightings and other major equipment which relates to patients and staff safety.					
	b) Emergency power supply system shall also provide the illuminations for exit signage, emergency lights, and nurse stations.					
	EVIDENCE OF COMPLIANCE				1. Endorsed as built drawing, i.e. for Electrical Standby Generator Set and for nurse call power supply	
	2. On-load and full load test records together with test schedule.					
	3. Relevant maintenance schedule (Planned Preventive Maintenance, Corrective Maintenance, Routine Inspection).					
	4. Periodic maintenance records					
5. Evidenced upon actual site inspection						
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
3.6.15.4	The number of electrical sockets ensures that:					
	i) No adaptors, extension cords and junction boxes shall be permitted in any room or area.					
	ii) There shall be adequate number of electrical sockets					
	EVIDENCE OF COMPLIANCE	1. Endorsed as built drawing.				
		2. Periodic maintenance records				
		3. Evidenced upon actual site inspection.				
Facility Comments:						

SURVEY ITEM & SELF-ASSESSMENT				
STANDARD 3.6.16	<u>ENERGY MANAGEMENT</u> <i>The Facility is planned with appropriate energy management programme to ensure effective usage of electrical energy as stipulated in the National Energy Commission guidelines that supports patient care objectives, safety of patients, staff and visitors.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
3.6.16.1	There is an energy management programme in place and include the following: a) A Certified Energy Manager (CEM) shall be appointed to manage the energy efficiency program. b) A Registered Electrical Energy Manager (REEM) shall be appointed by the Facility if the electrical consumption is more than three (3) million kWh for a period of six (6) months as required under the Efficient Management of Electrical Energy Regulation 2008, under the Electricity Supply Act 1990. c) The Sustainable Energy Management Committee shall be established to carry out the following activities with involvement of Energy Manager: i) establish policies and procedures, support the energy management committee to implement, maintain and continually improve on effective usage of electrical energy in accordance with the regulatory requirements; ii) identify, perform, set up energy target, plan and manage the energy consumption through the Sustainable Energy Management Programme (SEMP); iii) conduct technical audit that includes financial evaluation for energy conservation measure. d) energy management programme complies with regulatory requirements and should not compromise safety and comfort of patients and staff.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	EVIDENCE OF COMPLIANCE	1. Appointment of Registered Energy Manager OR Certified Energy Manager in accordance to National Energy Commission guidelines					
		2. Energy management programme is available					
		3. Energy audit reports					
		4. Copies of reports to Energy Commission					
		5. Minutes of Sustainable Energy Management Committee					
	Facility Comments:						

SURVEY ITEM & SELF-ASSESSMENT						
STANDARD 3.6.17	<u>CONNECTIVITY</u> <i>The facilities is equipped with secured and effective connectivity of high speed WIFI services</i>					
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
3.6.17.1	All healthcare organization need to develop and implement a contingency plan which must include disaster recovery plan.					
	EVIDENCE OF COMPLIANCE	1. Five (5) things to be in place in the disaster recovery plan (DRP)				
		a) Be proactive with DRP				
		b) Identify the organizations critical functions and infrastructure				
		c) Create emergency response policies and procedures				
		d) Document back up and restoration process				
		e) Perform routine test and drills				
	Facility Comments:					
3.6.17.2	Data in electronic medical record (EMR) must be stored for 6 years and all of it must be retractable at any point					
	EVIDENCE OF COMPLIANCE	1. Three (3) plans for backup recovery are:				
		a) Data backup				
		b) Disaster recovery plan				
		c) An emergency mode operation (EMOP) – An EMOP contains a process that enables organization to continue to operate in the event of disaster or system failure				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
3.6.17.3	Connectivity means is being in the quality of stable, state or capability of being connective.					
	EVIDENCE OF COMPLIANCE	1. Wi-Fi connectivity must ensure physician and others healthcare staff reachable.				
		2. Data recovery is a process of retrieving back data so it can be restored and utilized must be in place.				
		3. Back up data must be stored off premises to prevent loss of data if damage occurs to computer equipment.				
		4. An effective disaster recovery plan must be in place to restore the medical data and resume normal processes with minimal downtime in the (following) event of any type of data loss.				
		5. Important files must be back up at minimum once a week, preferably once every 24 hours which can be done manually or automatically.				
		6. Data backup and recovery must be in place as the process of backing up data in the event of loss. A system must be in placed to allow recovery of data and backup which will copy and archive computer data in case of corruption or deletion				
	Facility Comments:					

SURVEYOR SUMMARY:

OVERALL RISK:

SURVEY ITEM & SELF-ASSESSMENT				
SERVICE STANDARD 4 : NURSING SERVICES				
	<u>PREAMBLE</u> <i>The Nursing Services shall be delivered by capable, effective, competent, skillful, and highly knowledgeable nurses who will be able to provide Patient Centric Care which includes promotive, preventive, curative and rehabilitative services. Nurses care for the whole person; physically, mentally, emotionally, and spiritually. While caring for an individual, the nurse also cares for the family. Nurses provide care with respect and dignity for patients and their families.</i> <i>The Nursing Services shall be organised, directed and coordinated with the other services in the Facility to provide nursing care in a safe, efficient, effective and caring manner.</i>			
<u>TOPIC 4.1:</u> <u>STANDARD 4.1.1</u>	<u>ORGANISATION AND MANAGEMENT</u> <i>The Nursing Services shall offer high standard of care to the community, as outpatients and inpatients in a safe, effective, efficient and caring manner; and shall be organised, directed and coordinated with the other services in the Facility.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
4.1.1.1	Vision, Mission and value statements of the Facility are accessible. Philosophies, goals and objectives that suit the scope of the Nursing Services are clearly documented and measurable that indicates safety, quality and patient centred care. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.			

	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.				
		2. Philosophies, goals and objectives of the Nursing Services in line with the Facility statements are available, endorsed and dated.				
		3. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)				
		4. Achievement of goals and objectives are monitored, reviewed and revised accordingly.				
	Facility Comments:					
4.1.1.2 CORE	The organisational structure of the Nursing Services is clearly represented in one or more organisation charts which:					
	a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head of the Nursing Services, consultants, medical practitioners and staff of the Nursing Services;					
	b) is accessible to all staff and clients;					
	c) is revised when there is a major change in any of the following:					
	i) organisation;					
	ii) functions;					
	iii) reporting relationships;					
EVIDENCE OF COMPLIANCE	iv) staffing patterns.					
	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head of the Nursing Services and staff of the Nursing Services.					
	2. At each service level, a unit organisation chart is available which reflects the working relationships between consultants, medical practitioners and staff of the Nursing Services.					
	3. Organisation chart of the service is endorsed, dated and accessible.					
	4. The organisation chart is revised when there is a major change in any of the items (c)(i) to (iv).					
Facility Comments:						

4.1.1.3	Regular staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Nursing Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.					
	EVIDENCE OF COMPLIANCE	1. Minutes are accessible, disseminated and acknowledged by the staff.				
		2. Attendance list of members with adequate representatives of the service.				
		3. Frequency of meetings as scheduled.				
		4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).				
	Facility Comments:					
4.1.1.4	The Head of Nursing Services is involved in the planning, justification and management of the budget and resource utilisation of the services.					
	EVIDENCE OF COMPLIANCE	1. Minutes of Facility-wide management meeting				
		2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service.				
		3. Approved budget and resources				
	Facility Comments:					
4.1.1.5	The Head of Nursing Services is involved in the appointment and/or assignment of staff.					
	EVIDENCE OF COMPLIANCE	1. Records on staff interview (if applicable)				
		2. Appointment/assignment letter.				
		3. Job descriptions.				
		4. Records on staff deployment				
		5. Duty roster				
	Facility Comments:					
4.1.1.6	Appropriate statistics and records shall be maintained in relation to the provision of Nursing Services and used for managing the services and patient care purposes.					

	EVIDENCE OF COMPLIANCE	1. Records are available but not limited to the following:					
		a) staffing number and staff profile.					
		b) workload/census for inpatients and outpatients;					
		c) staff training records.					
		d) data on performance improvement activities including performances indicators and not limited to incident and near misses reports.					
	e) Annual report to Governing body						
Facility Comments:							
4.1.1.7	The Head of Nursing Services is responsible in planning, development and evaluation of nursing facilities and services.						
	EVIDENCE OF COMPLIANCE	1. Involvement of Nursing Ward Managers and HOS (where applicable) in the planning, development and implementation of new policies, facilities, and services					
		2. Minutes of meeting					
	Facility Comments:						
4.1.1.8	There is evidence that the Nursing Services are involved in the development and implementation of new technologies.						
	EVIDENCE OF COMPLIANCE	1. Involvement of the nursing staff on development and implementation of new technologies.					
		2. Minutes of departmental/management meeting					
	Facility Comments:						
4.1.1.9	Where the Facility provides clinical experience for students of nursing, there is a comprehensive documented agreement between the Facility and the educational institution detailing the responsibilities of all parties, which shall include:						
	a) time period; b) liability; c) review of terms of contract; d) accountability for clinical nursing practice.						

	EVIDENCE OF COMPLIANCE	1. Valid Memorandum of Understanding (MOU) or Agreement				
		2. Ratio of Clinical Instructor (CI) and students commensurate with the number of student (1:15)				
		3. Student ward allocation roster				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT							
TOPIC 4.2		HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT					
STANDARD 4.2.1		<i>The Nursing Services shall be directed by a qualified and experienced registered nurse, and adequately staffed to achieve the goals and objectives of the nursing services.</i>					
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
4.2.1.1	The Head and staff of the Nursing Services shall be individuals qualified by education, training, experience, certification and registration under the Nurses Registration Regulations 1985 to commensurate with the requirements of the various positions.				1.		
	EVIDENCE OF COMPLIANCE	1. Records on credentials of Head of Service and staff required to fill up the posts within the service (to match the complexity of the Facility and services) and certification/registration (Annual Practising Certificate).					
		2. Overall statistics of staff, qualification and experience					
		3. List of nurses with post basic certification in various disciplines.					
		4. Training and competency records					
		5. Deployment/assignment according to staff experience and speciality training.					
	Facility Comments:						
4.2.1.2	The Head of Nursing Services is a member of the Senior Management Team and sits on relevant committees of the Governing Body.						
	EVIDENCE OF COMPLIANCE	1. Valid appointment letters and Terms of Reference as member of committees stipulated by the Governing Body.					
		2. Minutes of relevant committee meetings					
	Facility Comments:						

4.2.1.3	The Head of Nursing Services shall designate a qualified registered nurse with the delegated responsibility for the management of the Nursing Services of each unit at all times.			
EVIDENCE OF COMPLIANCE	1.	Designated registered nurses are assigned to each unit with delegated responsibility for management of Nursing Services.		
	2.	Letters of appointment		
	3.	Job descriptions.		
	4.	Duty roster		
	Facility Comments:			
4.2.1.4	The assessment, planning, implementation and evaluation of nursing care is the responsibility and accountability of each and every registered nurse.			
EVIDENCE OF COMPLIANCE	1.	Sample of Nursing Care Plan to ensure complete nursing process is being carried out by registered nurses as stipulated in standard 4.3.1.9.		
	Facility Comments:			
4.2.1.5 CORE	Nursing staffing patterns shall reflect: a) patient needs and patient acuity level of care; b) staffing profile to comply with relevant guidelines and regulatory requirements: i) numbers; ii) credentials and privileges; iii) experience of the various categories of nursing staff. c) contingency staffing plan (absenteeism, turnover etc.).			
EVIDENCE OF COMPLIANCE	1.	Manpower planning and forecast of staffing needs.		
	2.	Qualified staff and patient ratio meet regulatory requirements		
	3.	Staff credentials and privileges.		
	4.	Verification of staffing needs in respective nursing service unit as reflected by:		
	a)	current assigned duty roster;		
	b)	patient acuity level of care;		

		c) skill mix;				
		d) written contingency plan for turnover and absenteeism;				
		e) documented staff deployment communication.				
	Facility Comments:					
4.2.1.6	There are written and dated specific job descriptions for all nursing staff that include: a) qualifications, training, experience and certification required for the position; b) lines of authority; c) accountability, functions and responsibilities; d) reviewed when required and when there is a major change in any of the following: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) Statutory Regulations. e) administrative, teaching and clinical functions.					
EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e).					
	2. Job description includes specialisation skills					
	3. Relevant privileges granted where applicable					
	4. The job description is acknowledged by the staff and signed by the Head of Service/Unit and dated.					
Facility Comments:						
4.2.1.7 CORE	There is structured orientation programme for all newly appointed staff to the Nursing Services and for those new to specific areas which shall include the following: a) Overview of Organization structure b) explanation of the philosophy, goals, objectives, policies and procedures of the Facility and those of the Nursing Services; c) lines of authority and areas of responsibility; d) explanation of particular duties and functions; e) explanation of the methods of assigning nursing care and the standards of nursing practice; f) handover communication in timely manner; g) processes for resolving practice dilemmas;					

	h) information about safety procedures; i) training in basic/advanced life support techniques; j) methods of obtaining appropriate resource materials; k) staff appraisal procedures for the Nursing Services; l) education on Patient and Family Rights; m) education on all types of Accreditation Standards.					
	EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme.				
		2. There is Nursing Services orientation programme with relevant topics not limited to topics covered from (a) to (m) and supported by an individual area/unit specific orientation programme.				
	Facility Comments:					
4.2.1.8	Staff receive evaluation of their performance at the completion of the probationary period and annually.					
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff is completed upon probationary period and as an annual exercise.				
	Facility Comments:					
4.2.1.9	There is evidence of training needs assessment and staff development plan which provide the knowledge and skills required for staff to maintain competency in their current positions and future advancement.					
	EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and gaps identified.				
		2. A staff development plan based on training needs assessment is available.				
		3. Training schedule/calendar is in place.				
		4. Training module				
		5. Evidence of staff capacity building assessment being monitored				
	Facility Comments:					

4.2.1.10	There are continuing nursing education activities for staff to pursue professional interests and to prepare for current and future changes in practice.					
	EVIDENCE OF COMPLIANCE	1. Training calendar includes in-house/external courses/workshop/conferences.				
		2. Contents of training programme				
		3. Training records on continuing nursing education activities are kept and maintained for each staff.				
		4. Certificate of attendance/degree/post basic training .				
	Facility Comments:					
4.2.1.11	Personnel records on training, staff development, leave and others are maintained for every staff.					
	Note: Staff personal record may be kept in Human Resource Department as per Facility policy.					
	EVIDENCE OF COMPLIANCE	1. Staff personal records include:				
		a) staff biodata;				
		b) qualification and experience;				
		c) evidence of current registration;				
		d) training record;				
		e) competency record and privileging;				
		f) leave record;				
	g) confidentiality agreement.					
Facility Comments:						
4.2.1.12	In a Facility where nursing education programmes are conducted, the Nursing Services shall ensure that there are sufficient skilled clinical nursing instructors with right credentials, experience, certification and privileged to provide clinical guidance and supervision of students.					
	EVIDENCE OF COMPLIANCE	1. Skilled Clinical Nursing Instructors with student ratio are appropriately met (1:15).				
		2. Written evidence to proof that continuous effort has been taken to ensure that sufficient skilled clinical nursing instructors are available at all times.				

		3. The Clinical Instructors have the right credentials and are privileged.				
		4. Signed Code of Conduct by Clinical Instructor.				
		5. Minutes of joint meeting between the Nursing Services with the Nursing College.				
	Facility Comments:					
4.2.1.13 CORE	The Nursing Services shall ensure the establishment of a mechanism which includes requirements, methodology and certification for credentialing and delineation of privileges for nurses in specialised areas for specific procedures. The mechanism taken by the Nursing Services shall adhere to the following:					
	a) the written policies and procedures documents the criteria for privileging;					
	b) the decisions made are objective, fair, and impartial and consistent with written policies, procedures and criteria;					
	c) the granting of privileges for a specified period of time;					
	d) the allocation of privileges in such a way that each staff functions within a specified area of competence;					
	e) the granting of privileges is approved by the Credentialing and Privileging Committee and certified by the Person In Charge (PIC)/Governing Body.					
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures are established to govern the credentialing and privileging processes for Nursing Services which includes but not limited to item (a) to (e).				
		2. There is a systematic validation process for each individual staff member of their credentials.				
		3. Skills competency is assessed regularly.				
		4. Formal letters of assignment or certificate of privileging with stipulated timeline are issued and reviewed accordingly.				
Facility Comments:						

SURVEY ITEM & SELF-ASSESSMENT				
TOPIC 4.3:	<u>POLICIES AND PROCEDURES</u>			
STANDARD 4.3.1	<i>There are written and dated policies and procedures for all activities of the Nursing Services. These policies and procedures reflect current standards of nursing services and practice, relevant regulations, statutory requirements, and the purposes of the services.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
4.3.1.1 CORE	There are written policies and procedures for the Nursing Services which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices which include: a) policies and procedures, applicable laws and regulations that guide uniform nursing care of all patients; b) policies and procedures that guide the care of high risk patients and high risk services: i) emergency patients; ii) use of resuscitation services; iii) administration of blood and blood products; iv) patients on life support/comatose; v) patients with communicable disease; vi) immuno-compromised patients; vii) patients on dialysis; viii) care of patients on restraints; ix) care of elderly patients; x) disabled individuals and children; xi) patients receiving chemotherapy and other high risk medications. c) policies and procedures on patient nutrition and hygiene. These policies and procedures are signed, authorised and dated. There is a mechanism for and evidence of a periodic review at least once in every three years.			
EVIDENCE OF COMPLIANCE	1. Documented Policies and Procedures, Protocols, Manuals and Guidelines are available to guide nursing care for:			
	a) general care of all patients;			
	b) high risk patients as those mentioned in but not limited to (b)			

		2. Policies and procedures on patient nutrition and hygiene.				
		3. Policies and procedures are consistent with regulatory requirements and current standard practices.				
		4. Evidence of periodic review of policies and procedures.				
		5. The policies and procedures are endorsed and dated.				
	Facility Comments:					
4.3.1.2	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved.					
	Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.					
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.				
		2. Minutes of meeting with evidence of cross reference with other departments.				
		3. Documented cross departmental policies and procedures.				
	Facility Comments:					
4.3.1.3	Current policies and procedures are communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings				
		2. Circulation list and acknowledgement				
	Facility Comments:					
4.3.1.4 CORE	There is evidence of compliance with policies and procedures.					
	EVIDENCE OF COMPLIANCE	1. Compliance with policies and procedures through:				
		a) interview of staff on practices;				
		b) verify with observation on practices;				
		c) results of audit on practices;				

		d) Evidence in nursing documentation in line with established policies and procedures.				
		Facility Comments:				
4.3.1.5		Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.				
	EVIDENCE OF COMPLIANCE	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.				
		Facility Comments:				
4.3.1.6		The Head of Nursing Services is responsible for the organisation, documentation and implementation of nursing policies and procedures.				
	EVIDENCE OF COMPLIANCE	1. Policies and procedures for the Nursing Services are endorsed by the Head of Nursing Services.				
		Facility Comments:				
4.3.1.7		The Nursing Services participate in planning, decision making and formulation of policies of the Facility.				
	EVIDENCE OF COMPLIANCE	1. List of committees where the Head of the Nursing Services is involved.				
		2. Minutes of Management meetings				
		Facility Comments:				
4.3.1.8		The Nursing Services have an established initial assessment process for patients where their nursing needs are identified and followed by regular reassessment as deemed necessary.				

	EVIDENCE OF COMPLIANCE	1. Nursing assessment done and completed within 24 hours of admission.				
		2. Nursing reassessment done as needed.				
		3. Nursing Care Plan documented after each nursing round with progress of patient's condition, dated and signed off by attending registered nurse.				
	Facility Comments:					
4.3.1.9 CORE	Nursing practice is in accordance with current accepted standards based on evidences and shall include in the nursing care plan:					
	a) documented individualised patient-focused nursing care plan for each patient to achieve appropriate outcomes of care;					
	b) monitoring of the patient to assess the outcome of the care of patient;					
	c) reviewing and modifying the care plan where appropriate;					
	d) completing the care plan.					
	e) planning and follow up, to include discharge planning that reflects continuity of care;					
	f) patient education which shall be documented.					
	EVIDENCE OF COMPLIANCE	1. Implementation of Nursing Care Plan based on patient's need as stated in (a) – (f)				
		2. Documented Nursing Care Plan signed and dated.				
		3. Continuity of patient care i.e. intra & inter departmental handover.				
		4. Patient discharge plan includes patient education.				
		5. Evidence based nursing services such as Bundle of Care is adopted where applicable and appropriate.				
		6. Compliance to National Patient Safety Goals related to nursing services.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT							
TOPIC 4.4:		<u>FACILITIES AND EQUIPMENT</u>					
STANDARD 4.4.1		<i>There are adequate and appropriate facilities and equipment at each nursing unit for providing safe and efficient nursing services according to standards set by the relevant authorities and regulatory requirements.</i>					
	CRITERIA FOR COMPLIANCE:				SELF RATING	SURVEYOR FINDINGS	
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
4.4.1.1	There are adequate and appropriate facilities and equipment with proper utilisation of space at each unit to allow staff to carry out nursing services safely and efficiently.						
	EVIDENCE OF COMPLIANCE	1. Adequate and proper utilisation of space.					
		2. Appropriate type of equipment to match the complexity of services.					
		3. Adequate facilities and equipment at each patient care area for safe care. (e.g. defibrillators, emergency cart, hand washing facilities etc)					
		4. Easy access and clear exit routes					
	Facility Comments:						
4.4.1.2	Nursing Services are provided with sufficient supplies and equipment at all times, including appropriate personal protective equipment.						
	EVIDENCE OF COMPLIANCE	1. Adequate equipment and supplies for Nursing Services.					
		2. Equipment are replaced in a planned and systematic manner.					
		3. Stock inventory including personal protective equipment are according to par level.					
		4. Accessibility of critical equipment and consumables at all times.					
		5. Equipment has valid Planned Preventive Maintenance (PPM).					
	Facility Comments:						

4.4.1.3	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.					
	EVIDENCE OF COMPLIANCE	1. User training records				
		2. Competency assessment record				
		3. Letter of authorisation				
		4. List of staff trained and authorised to operate specialised equipment				
	Facility Comments:					
4.4.1.4	There are sufficient change rooms, rest areas for staff use and storage including safekeeping of their personal items.					
	EVIDENCE OF COMPLIANCE	1. Provision of adequate staff restroom with staff personal lockers or equivalent to keep staff personal belongings with adequate security.				
		2. Changing rooms at relevant care areas where appropriate.				
	Facility Comments:					
4.4.1.5	Facilities which provide nursing training shall have specific areas for training and rooms for tutorial.					
	EVIDENCE OF COMPLIANCE	1. Availability of training/tutorial areas/rooms.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT					
TOPIC 4.5:		<u>SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES</u>			
STANDARD 4.5.1		<i>The Head of Nursing Services shall ensure the provision of quality performance and safety of patients with staff involvement in continuous safety and performance improvement activities of Nursing Services in risk mitigation.</i>			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
4.5.1.1	Clinical initiative to reduce risk & harm is systematically planned to minimise the adverse consequence of patient outcomes & liability .The process includes a) Planned activities i.e. risk identification using the risk rating matrix and develop risk register. b) Review risk register periodically c) Data collection and verification d) Monitoring and evaluation of the performance e) Action plan for improvement f) Implementation of action plan g) Re-evaluation for improvement Innovation is advocated.				
	EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to (g)			
		2. Records on performance improvement activities/studies			
		3. Minutes of performance improvement meetings			
		4. Nursing Risk register			
		5. Evidence of risk register been reviewed.			
		6. Records on innovation if available			
	Facility Comments:				
4.5.1.2	The Head of Nursing Services has assigned responsibilities for planning, monitoring and managing safety and performance improvement activities to appropriate individual/personnel within the respective services.				

	EVIDENCE OF COMPLIANCE	1. Collection, tabulation & verification of data				
		2. Discuss with relevant department/committee				
		3. Identify areas for improvement				
		4. Endorsement of outcome by the Head of Nursing and PIC				
	Facility Comments:					
4.5.1.3	The Head of Nursing Services shall ensure that the staff are trained in incident reporting. Incident reports are timely reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility.					
	Incidents reported have Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.					
	EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:				
		a) Training of staff				
		b) Policy on incident reporting				
		c) Methodology of incident reporting				
		d) Register/records of incidents				
		2. Timely complete incident reports				
		3. Root Cause Analysis				
		4. Corrective and preventive action plans				
		5. Remedial measure implemented and monitored				
		6. Minutes of meetings				
		7. Acknowledgment by Head of Service and PIC/Hospital Director				
		8. Outcome of lessons learnt from the incident shared with others				
	Facility Comments:					

4.5.1.4 CORE	There is evidence of tracking and trending of specific performance indicators for improvement of the services / patient care such as percentage of intravenous (I/V) line complications (needles out, redness of skin, infection of sites, extravasation) (Target: ≤ 0.5%)					
	EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored.				
		2. Records on tracking and trending analysis.				
		3. Remedial measures taken where appropriate				
		4. Review performance indicators if trending shows consistent achievement over one year. Identify new performance indicator where applicable.				
	Facility Comments:					
4.5.1.5	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.					
	EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff.				
		2. Evidence of feedback (e.g., audit on Hand Hygiene, Safe Surgery Saves Lives, Patient Identification, Patient Fall, Pressure Ulcer and etc) via communication on results of performance improvement activities through continuing nursing education activities/meetings.				
		3. Minutes of service/unit/committee meetings				
	Facility Comments:					
4.5.1.6	Appropriate documentation of safety and performance improvement activities are kept, and confidentiality of medical practitioners, staff and patients is preserved.					
	EVIDENCE OF COMPLIANCE	1. Documentations on performance improvement activities and performance indicators.				
		2. Policy statement on anonymity on patients and providers involved in performance improvement activities.				
	Facility Comments:					

SERVICE SUMMARY	
SURVEYOR SUMMARY:	
OVERALL RATING:	
OVERALL RISK:	

SURVEY ITEM & SELF-ASSESSMENT				
SERVICE STANDARD 5 : PREVENTION AND CONTROL OF INFECTION				
	<u>PREAMBLE</u> <i>These standards are applicable to affect facility-wide Prevention and Control of Infection Services. The aim of the service is to identify and minimize the risks and development of healthcare associated infection, the emergence of antimicrobial resistance and the transmission of these infection among patients, families, healthcare providers, staff of contracted services, students, and visitors.</i> <i>Adherence to the current national and international health policies, procedures and regulatory requirements are necessary to improve prevention and control of healthcare associated infections. Preventing the spread of antimicrobial resistance also requires appropriate and responsible use of antimicrobials</i>			
<u>TOPIC 5.1:</u> <u>STANDARD 5.1.1</u>	<u>ORGANISATION AND MANAGEMENT</u> <i>The Prevention and Control of Infection (PCI) Services and Antimicrobial Stewardship Services (AMS) are organised and administered to provide optimum support to the Vision, Mission, goals and objectives of the Facility, towards the implementation of safe infection control practices in line with current national and international health policies, procedures and regulatory requirements.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
5.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Prevention and Control of Infection Services and Antimicrobial Stewardship Services are clearly documented and measurable that indicates safety, quality and patient centred care. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.			

	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.				
		2. Goals and objectives of the Prevention and Control of Infection Services and Antimicrobial Stewardship Services in line with the Facility statements are available, dated and endorsed.				
		3. Evidence of planned reviews of the above statements.				
		4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)				
		5. Achievement of goals and objectives are monitored, reviewed and revised accordingly				
	Facility Comments:					
5.1.1.2	There is an organisation chart which:					
	a) provides a clear representation of the structure and functions of the Facility's Hospital Infection and Antibiotic Control Committee (HIACC) and the reporting relationships of the PCI Team and AMS Team to the HIACC.					
	b) is accessible to all relevant staff in PCI and AMS.					
	c) is revised when there is a major change in any of the following:					
	i). organisation. ii). functions. iii). reporting relationships. iv). staffing patterns.					
	EVIDENCE OF COMPLIANCE	1. Clearly delineated current organisation chart with line of functions and reporting relationships.				
		2. Organisation chart of the services endorsed, dated and accessible.				
		3. The organisation chart is revised when there is a major change in any of the items (c)(i) to (iv).				
	Facility Comments:					
5.1.1.3 CORE	There is a Hospital Infection and Antibiotic Control Committee (HIACC) chaired by a medical practitioner with knowledge of and special interest in infection control and antimicrobial stewardship. The HIACC consists of members from multidiscipline					

	(medical, nursing and clinical support services, and by invitation administration and any other relevant staff). The committee has: a) Appointment of a Chairperson b) Terms of Reference c) Committee members d) Tenure of membership e) Frequency of meetings <table><tr><td rowspan="5">EVIDENCE OF COMPLIANCE</td><td>1. Establishment of HIACC</td><td></td></tr><tr><td>2. Appointment letters of committee members</td><td></td></tr><tr><td>3. Terms of Reference</td><td></td></tr><tr><td>4. Minutes of meeting</td><td></td></tr><tr><td>5. Qualification of Chairperson</td><td></td></tr></table> Facility Comments:	EVIDENCE OF COMPLIANCE	1. Establishment of HIACC		2. Appointment letters of committee members		3. Terms of Reference		4. Minutes of meeting		5. Qualification of Chairperson				
EVIDENCE OF COMPLIANCE	1. Establishment of HIACC														
	2. Appointment letters of committee members														
	3. Terms of Reference														
	4. Minutes of meeting														
	5. Qualification of Chairperson														
5.1.1.4 CORE	The Prevention and Control of Infection (PCI) Team and Antimicrobial Stewardship (AMS) Team has a working relationship and reports to the HIACC. The PCI Team shall be headed by Infection Control Doctor Coordinator and assisted by trained and Infection Control Nurses. The AMS Team shall be headed by AMS Coordinator and assisted by trained and related personnel in AMS activities. <table><tr><td rowspan="4">EVIDENCE OF COMPLIANCE</td><td>1. Appointment letters of • PCI Unit/Team member • AMS member </td><td></td></tr><tr><td>2. Terms of Reference for PCI/AMS Team members</td><td></td></tr><tr><td>3. Infection control activities reports and discussion</td><td></td></tr><tr><td>4. Antimicrobial stewardship activities reports and discussion</td><td></td></tr></table> Facility Comments:	EVIDENCE OF COMPLIANCE	1. Appointment letters of • PCI Unit/Team member • AMS member		2. Terms of Reference for PCI/AMS Team members		3. Infection control activities reports and discussion		4. Antimicrobial stewardship activities reports and discussion						
EVIDENCE OF COMPLIANCE	1. Appointment letters of • PCI Unit/Team member • AMS member														
	2. Terms of Reference for PCI/AMS Team members														
	3. Infection control activities reports and discussion														
	4. Antimicrobial stewardship activities reports and discussion														

5.1.1.5	The link nurse/link personnel act as a link between the staff in the ward/service units and the infection control team while the link ward pharmacists act as a link between the staff in the ward/service units and the antimicrobial stewardship team.				
	EVIDENCE OF COMPLIANCE	1. Appointment letters for link nurses/link personnel			
		2. Description of duties and responsibilities for link nurses/link personnel			
		3. Appointment letters for link ward pharmacist			
		4. Description of duties and responsibilities for link ward pharmacists			
	Facility Comments:				
5.1.1.6 CORE	HIACC meetings shall be held at least once in every 6 month and whenever necessary to discuss issues matters pertaining to the operations of the PCI services and AMS relevant activities. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.				
	EVIDENCE OF COMPLIANCE	1. Minutes are accessible, disseminated and acknowledged by the members			
		2. Attendance list of members with adequate representatives of the committee			
		3. Frequency of meetings as scheduled.			
		4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).			
	Facility Comments:				
5.1.1.7	The Chairman of HIACC and / or the Head of Prevention and Control of Infection (PCI), is involved in planning, justification and management of budget and resource utilisation of the services.				
	EVIDENCE OF COMPLIANCE	1. Minutes of HIACC meeting			
		2. Minutes of facility-wide management meeting			
		3. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service – if applicable			

		4. Approved budget and resources – if applicable				
	Facility Comments:					
5.1.1.8	The Head of PCI services and AMS relevant activities. is involved in the assignment of staff.					
	EVIDENCE OF COMPLIANCE	1. Assignment letter of Head of PCI/AMS				
		2. Job description of Head of PCI/AMS				
		3. Records on staff deployment PCI/AMS				
		4. Duty roster • PCI • AMS				
	Facility Comments:					
5.1.1.9	Appropriate statistics and records shall be maintained in relation to the provision of PCI Services and AMS relevant activities and used for managing the services and patient care purposes.					
	EVIDENCE OF COMPLIANCE	1. Records are available but not limited to the following:				
		a)	surveillance reports – laboratory based and clinical based;			
		b)	audit reports, e.g. environment, etc			
		c)	antibiotic resistance pattern;			
		d)	incident reports;			
		e)	staffing number and staff profile;			
		f)	staff training records;			
	g)	data on performance improvement activities, including performance indicators.				
		h) antimicrobial usage data of broad spectrum antibiotics (eg Carbapenems, Vancomycin				
	Facility Comments:					

5.1.1.10	Where more than one committee have interests in the issues of the PCI services and AMS relevant activities, there is evidence of coordination of the actions undertaken or proposed by the committees. Records are kept on actions taken to identify and correct the cause of any problem.					
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings, e.g. Health and Safety Committee, Operating Theatre Committee, Equipment Procurement Committee, etc.				
	Facility Comments:					
5.1.1.11	There are safety measures taken to ensure the protection of the Facility's staff and environment against healthcare associated infections. Records shall be kept on action taken which include: a) staff education; b) staff health screening including infectious diseases; c) staff immunisation; d) staff health record maintenance; e) provision for adequate and good quality personal protective equipment (PPE); f) implementation of safety devices; g) clinical waste management; h) protocol for post-exposure management for infectious disease and for assignment of infected staff.					
	EVIDENCE OF COMPLIANCE	1. Where appropriate, records are kept on actions taken which include items (a) to (h).				
	Facility Comments:					

5.1.1.12	Provision is made for the personal comfort and safety of patients and staff which include:				
	a) clean and hygienic facilities; b) room temperatures are kept at comfortable levels; c) disinfection and sterilisation areas; safe equipment and instruments; d) proper hand hygiene facilities; e) aseptic techniques for procedures; f) practice of standard and transmission-based precautions; g) adequate PPE supplies; h) appropriate well ventilated facilities				
	EVIDENCE OF COMPLIANCE	1. There is evidence of items (a) to (h) being implemented.			
	Facility Comments:				

SURVEY ITEM &SELF-ASSESSMENT							
<u>TOPIC 5.2</u>		<u>HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT</u>					
<u>STANDARD</u> <u>5.2.1</u>		<i>The PCI Services shall be staffed by adequate numbers of appropriately qualified, trained and certified staff to achieve the goals and objectives of the service. These designated staff shall maintain competency through Continuing Professional Development (CPD).</i>					
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
5.2.1.1	The Head and staff of the PCI services and AMS relevant activities. shall be individuals qualified by education, training, experience and certification to commensurate with the requirements of the various positions.						
	EVIDENCE OF COMPLIANCE	1. Records on credentials of Head of Service/Team and staff required to fill up the posts within the service (to match the complexity of the Facility and services).					
		2. Assignment letters					
		3. Certification					
		4. Training and competency records including privileging (for PCI & AMS)					
	Facility Comments:						
5.2.1.2	The authority, responsibilities and accountabilities of the Head of PCI services and AMS relevant activities. are clearly delineated and documented.						
	EVIDENCE OF COMPLIANCE	1. Appointment/assignment letter for Head of Service					
		2. Description of duties and responsibilities.					
	Facility Comments:						

5.2.1.3 CORE	The infection control nurse (ICN) shall have post basic/advanced diploma infection control training and certified. The AMS pharmacist shall have attended the AMS pharmacist training program and be certified.					
	EVIDENCE OF COMPLIANCE	1. PCI - Post basic /advanced diploma infection control qualification.				
		2. AMS – AMS pharmacist has AMS pharmacist training program				
	Facility Comments:					
5.2.1.4	The head of PCI Services/Team is responsible for the effective implementation of infection control policies and activities The head of AMS services/team is responsible for the effective implementation of antimicrobial stewardship policies and activities					
	EVIDENCE OF COMPLIANCE	1. Surveillance/audit reports and records				
		2. Environmental inspection records				
		3. On-site training records conducted by • ICN in-charge • AMS trained pharmacist				
	Facility Comments:					
5.2.1.5 CORE	Sufficient numbers of personnel and support staff including link nurses/link personnel and link pharmacists with appropriate qualifications are employed to meet the need of the services according to national norms					
	EVIDENCE OF COMPLIANCE	1. Full time staff (Infection Control Nurse) in accordance with national norm commensurate with bed occupancy rate.				
		2. Appointed pharmacist (AMS trained, when available)				
		3. Availability of in each ward/unit. • link nurses/link personnel • ward pharmacist (where applicable)				
		4. Census and statistics				
	Facility Comments:					

5.2.1.6	There are written and dated specific job descriptions for members of PCI services and AMS relevant activities. that include: a) qualifications, training, experience and certification required for the position; b) lines of authority; c) accountabilities, functions and responsibilities; d) reviewed when required and when there is a major change in any of the following: - i). nature and scope of work; - ii). duties and responsibilities; - iii). general and specific accountabilities; - iv). qualifications required and privileges granted; - v). staffing patterns; - vi). Statutory Regulations. e) administrative and clinical functions.			
EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e).			
	2. Job description includes specialisation skills			
	3. Relevant privileges granted where applicable			
	4. The job description is acknowledged by the staff and signed by the Head of Service/Team and dated.			
	Facility Comments:			
5.2.1.7	There is a structured orientation programme where new PCI services and AMS relevant activities. members are briefed on their services, operational policies and relevant aspects of the Facility to prepare them for their roles and responsibilities.			
EVIDENCE OF COMPLIANCE	1. Policy requiring all new team members to attend structured orientation programme.			
	2. Records on structured orientation programme			
	3. Orientation module			
	4. List of attendance			
	Facility Comments:			

5.2.1.8	There is evidence of training needs assessment and staff development plan which provide the knowledge and skills required for staff to maintain competency in their current positions and future advancement.					
	EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and gaps identified.				
		2. A staff development plan based on training needs assessment is available.				
		3. Training schedule/calendar is in place.				
		4. Training module.				
	Facility Comments:					
5.2.1.9	There are continuing education activities for staff to pursue professional interests and to prepare for current and future changes in practice.					
	EVIDENCE OF COMPLIANCE	1. Training calendar includes in-house/external courses/workshop/conferences.				
		2. Contents of training programme.				
		3. Training records on continuing education activities are kept and maintained for each staff.				
		4. Certificate of attendance/degree/advanced diploma/post basic// training.				
	Facility Comments:					
5.2.1.10	There is evidence that all PCI staff have the opportunity to attend additional training in the conduct of procedures unique to the services such as the operating rooms, obstetrical units, emergency services, special care units, Central Sterilising Supply Services and isolation rooms etc.					
	EVIDENCE OF COMPLIANCE	1. Training records on prevention of healthcare associated infections and the roles of the staff in specialised areas.				
		2. Training on safety measures in high risks areas such as the central sterilising supply services, operating theatres, scope rooms, critical care areas, immunocompromised patient areas, kitchens, laundry, laboratories and radiation emission areas etc.				
	Facility Comments:					

5.2.1.11 CORE	The PCI services and AMS relevant activities. are involved in orientation and in-service education for all staff including medical practitioners, house officers, students, volunteers, staff of contracted services, family members and patients where appropriate.					
	EVIDENCE OF COMPLIANCE	1. Facility-wide orientation programme • PCI • AMS				
		2. Link nurses/link personnel orientation programme				
		3. Pharmacist orientation program				
		4. Outsourced services' staff orientation programme • PCI				
		5. Patient and family members orientation checklist • PCI				
	Facility Comments:					

SURVEY ITEM &SELF-ASSESSMENT						
TOPIC 5.3:		<u>POLICIES AND PROCEDURES</u>				
STANDARD <u>5.3.1</u>		<i>Documented policies and procedures shall reflect the current knowledge on prevention and practice of infection control services, and they are consistent with the goals and objectives of the services and relevant regulations and statutory requirements.</i>				
				SURVEYOR FINDINGS		
		CRITERIA FOR COMPLIANCE:	SELF RATING	AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
5.3.1.1 CORE	There are written policies and procedures for the PCI services and AMS relevant activities. relevant to the scope of services, complexity of the Facility and level of risks consistent with national and international requirements. These policies and procedures are signed, authorised and dated.					
	There is a mechanism for an evidence of a periodic review at least once in every three years. Update on relevant topics shall be made earlier if required.					
	EVIDENCE OF COMPLIANCE	1. Facility-wide infection control policies and procedures which are customised to the complexity of the services provided. The policies and procedures address the following:				
		a) preventive and control procedures for all aseptic techniques and practices related to sterilisation and disinfection;				
		b) fight against antimicrobial resistance;				
		c) use of personal protective equipment (PPE);				
		d) healthcare associated infection and isolation (patients and visitors);				
		e) central sterilising supply services;				
		f) housekeeping services;				
		g) laundry services;				
		h) food handling;				
i) handling of sharps and waste;						

		j) pharmacy services;					
		k) surgical and nursing procedures;					
		l) pathology services;					
		m) engineering services;					
		n) ventilation system;					
		o) facility and equipment maintenance, and all others.					
		2. Facility-wide Antimicrobial policy which are customised to the complexity of the services provided. The policies should, as a minimum, address the following:					
		a) Objectives of the policy					
		b) AMS Principles of antimicrobial usage in the facility (eg documentation of indication for the antimicrobial prescribed)					
		c) Hospital Antimicrobial formulary					
		d) List of restricted antimicrobials					
		e) Approval processes for restricted antimicrobials					
		f) Any Quality Improvement initiatives planned to improve antimicrobial prescribing in the facility					
		3. Current Ministry of Health Policies and Procedures on Infection Control are available for reference (updates).					
		4. An AMS protocol that is available for reference. (e.g. Ministry of Health Protocol on Antimicrobial Stewardship in Healthcare Facilities)					
		5. Evidence of periodic review of policies and procedures.					
		6. The policies and procedures are endorsed and dated.					
Facility Comments:							
5.3.1.2	Policies and procedures are developed by a committee in collaboration with various disciplines involving representatives from medical practitioners, <u>pharmacy</u> , nursing, management, engineering and where required with other external service providers and with reference to relevant sources involved.						

	Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.					
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on consultation with PCI teams when planning relevant policies (eg OT committees, OSH)				
	Facility Comments:					
5.3.1.3	Current guidelines, policies and procedures are communicated to all facility staff.					
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings.				
		2. Circulation list and acknowledgement.				
	Facility Comments:					
5.3.1.4 CORE	There is evidence of compliance with policies and procedures and evidence based guidelines (World Health Organization/ Centres for Disease Control and Prevention/Ministry of Health) as stated in 5.3.1.1.					
	EVIDENCE OF COMPLIANCE	1. Infection control practices (on-site observation) in each of the areas mentioned (5.3.1.1).				
		2. Audit reports on infection control practices				
		3. Healthcare associated infection outbreak investigations and reports investigated and reported investigations and reports				
		4. Staff health status report on cases related to infection control				
		5. Compliance with National or local antibiotic guidelines.				
		6. Data collection on Antimicrobial resistance reports				
		7. Data collection on usage of broad spectrum or restricted antimicrobials				
	Facility Comments:					
	5.3.1.5	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.				

	EVIDENCE OF COMPLIANCE	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.		
	Facility Comments:			
5.3.1.6	Current reference manuals, pamphlets, journals, and books as well as information and scientific data concerning infection control and antimicrobial stewardship shall be available for reference and guidance.			
	EVIDENCE OF COMPLIANCE	1. Copies of relevant documents for reference and guidance.		
	Facility Comments:			
5.3.1.7	Regular "environmental infection risks" (e.g. air, water and surface environment) inspections are conducted throughout the Facility for the purpose of quality improvement and the updating policies and procedures related to infection control practices.			
	EVIDENCE OF COMPLIANCE	1. Report/documentation on infection risks environmental inspections (e.g. air, water and surface environment)		
		2. Corrective and preventive actions taken, e.g. training, improvement of infection control practices and other activities.		
	Facility Comments:			
5.3.1.8	The PCI Unit/Team shall be consulted in order to ensure that: a) proposed demolition, building constructions and renovations are designed in line with accepted infection control requirements. b) proposed new equipment (critical and semi critical medical devices) intended for patient care conforms to accepted infection control standards.			

	EVIDENCE OF COMPLIANCE	1. Records on input from PCI Unit/Team for (a) and (b) where applicable.				
	Facility Comments:					
5.3.1.9 CORE	The HIACC reviews reports on healthcare associated infections rates, surveillance studies of infections and infection potentials, and the implementation of infection control and antimicrobial stewardship policies. Pertinent findings shall be submitted to the appropriate source for necessary action.					
	EVIDENCE OF COMPLIANCE	1. Minutes of HIACC meeting				
		2. Reports on: -				
		a) healthcare associated infection rates;				
		b) surveillance data on infections and infection potentials;				
		c) implementation of infection control policies.				
		d) Antimicrobial usage of broad spectrum and restricted antimicrobials				
		e) Any pertinent relevant report (e.g outbreak report)				
	3. Records on pertinent findings submitted to the appropriate source for necessary action to be taken.					
	Facility Comments:					
5.3.1.10	Policies and procedures for infectious patients and those requiring isolation and treatment are available and complied including the following: a) proper isolation of infectious cases based on mode of transmission. b) hand hygiene practices. c) the isolated patients receive the same quality of care as is provided throughout the Facility.					
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures include (a), (b) and (c).				
		2. Patient's orientation checklist (briefing on infection control practices)				
		3. Records on implementation of (a), (b) and (c)				
		4. Validation upon on-site inspection of items (a), (b) and (c).				
	Facility Comments:					

SURVEY ITEM &SELF-ASSESSMENT									
TOPIC 5.4: FACILITIES AND EQUIPMENT									
STANDARD 5.4.1 Adequate facilities and equipment are available to prevent and control the risks of infection throughout the Facility including disinfection and sterilisation areas.									
	CRITERIA FOR COMPLIANCE:				SELF RATING	SURVEYOR FINDINGS			
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
5.4.1.1	There are adequate and appropriate facilities and equipment with proper utilisation of space for disinfection and sterilization process. patient management to enable staff to carry out their professional and administrative functions.								
	EVIDENCE OF COMPLIANCE	1. Adequate and proper utilisation of space							
		2. Space for admin functions							
		3. Appropriate type of equipment to match the complexity of services and to prevent and control the risks of infection.							
		4. Easy access and clear exit routes							
	Facility Comments:								
5.4.1.2 CORE	The use of all medical devices and disinfectants shall comply with the manufacturers' instructions on prevention and control of infection.								
	EVIDENCE OF COMPLIANCE	1. Manufacturers' instructions on medical devices and disinfectants for prevention and control of infection are in place for reference.							
		2. Material Safety Data Sheet (MSDS) for chemical used is available.							
		3. Records and observation on practices.							
	Facility Comments:								

5.4.1.3	Where single use devices or instruments are to be reused, the processes for reprocessing are consistent with relevant international standard.					
	EVIDENCE OF COMPLIANCE	1. Policy on reprocessing of single use devices.				
		2. Observation on practice upon on-site inspection				
	Facility Comments:					
5.4.1.4	Adequate personal protective equipment (PPE) shall be provided for healthcare providers, patients and visitors where appropriate.					
	EVIDENCE OF COMPLIANCE	1. Records on requests and supplies of PPE				
		2. Observation on practice upon on-site inspection				
	Facility Comments:					
5.4.1.5	Isolation facilities for patient requiring transmission-based precaution of airborne infection and immunocompromised patients shall comply with regulatory requirements.					
	EVIDENCE OF COMPLIANCE	1. Isolation rooms available with negative or positive pressure gauge monitoring and airlock with PPE facilities.				
		2. Record of maintenance shall be kept				
	Facility Comments:					
5.4.1.6	Adequate and appropriate hand hygiene facilities including alcohol-based hand rub shall be available in all patient, staff and visitor areas.					
	EVIDENCE OF COMPLIANCE	1. Availability and appropriate hand washing facilities in all patient, staff and visitor areas.				
		2. Availability of alcohol-based hand rubs in all patient, staff and visitor areas.				
	Facility Comments:					

SURVEY ITEM &SELF-ASSESSMENT						
TOPIC 5.5:		<u>SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES</u>				
STANDARD <u>5.5.1</u>		<i>The Head of PCI Services and AMS Team shall ensure the provision of safe and quality performance with staff involvement in the continuous safety and performance improvement activities of the PCI and AMS relevant activities. This can be achieved through actively monitoring and tracking risks and trends in healthcare associated infections and antibiotic prescription pattern.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
5.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the PCI services and AMS relevant activities. The process includes: a) Data collection b) Action plan for improvement based on existing data c) Implementation of action plan using PDSA concept d) Re-evaluation for improvement e) Monitoring and evaluation of the performance Innovation is advocated.					
	EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to (e)				
		2. Records on performance improvement activities.				
		3. Minutes of performance improvement meetings				
		4. Performance improvement studies				
		5. Records on innovation if available				
	Facility Comments:					
5.5.1.2	The Head of PCI services and AMS relevant activities. has assigned the responsibilities for planning, monitoring and managing safety and performance improvement activities to appropriate individual/ personnel/ committee					

	EVIDENCE OF COMPLIANCE	1. Minutes of meetings				
		2. Letter of assignment of responsibilities				
		3. Terms of Reference/Job description				
	Facility Comments:					
5.5.1.3	The Head of PCI Services shall ensure that the staff are trained in outbreak management. The outbreak shall be promptly investigated, and appropriate action taken. Report is forwarded to the Person in Charge (PIC) of the Facility.					
	EVIDENCE OF COMPLIANCE	1. System for outbreak management and reporting is in place, which include:				
		a) Protocol on outbreak management				
		b) Methodology of outbreak management				
		c) Register/records of outbreak				
		2. Training of staff				
		3. Completed outbreak reports				
		4. Corrective and preventive action plans				
		5. Minutes of meetings				
		6. Acknowledgment by Head of Service and PIC/Hospital Director				
		7. Feedback given to staff regarding outbreak				
	Facility Comments:					
5.5.1.4 CORE	For Infection Control, there is tracking, and trending of specific performance indicators not limited to but at least two (2) of the following: a) percentage of staff trained in Prevention and Control of Infection practices b) Rate of healthcare associated infections c) number of resistant organisms to antibiotics within a specified period of time For Antimicrobial stewardship, there is tracking, and trending of specific performance indicators for at least one (1) of the following: a) percentage of appropriate and complete antimicrobial prescriptions b) percentage of prescriptions with indications that are in keeping with national or local antimicrobial guidelines c) Percentage of empirical prescriptions that are reviewed by 72 hours					

	EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored. • PCI • AMS				
		2. Records on tracking and trending analysis. • PCI • AMS				
		3. Remedial measures taken where appropriate • PCI • AMS				
		4. Monitoring of PCI indicators:				
		a)				
		i). 100% link nurses/link personnel to undergo minimum three (3) days training				
		ii). 100% of new staff including medical practitioners given orientation on infection control within 3 months				
		iii). 85% of existing staff including medical practitioners trained on infection control.				
		b)				
		i). Healthcare associated infection rate based on current national targets (Target: less than 5%)				
		ii). Clinical based surveillance:				
		• Surgical Site Infection of selected operation based on current local / national / international targets (e.g. clean operation less than 2%);				
		• Catheter Associated Urinary Tract Infection (CAUTI);				
		• Ventilator-associated Pneumonia (VAP) based on current local / national / international targets (Target: <10 per 1000 ventilator days)				
		• Catheter Related Infection (e.g. CRBSI) based on current local / national / international targets (Target: <5 per 1000 catheter days)				
		c) Healthcare Associated MDRO surveillance:				
		i). Methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)–based on current national targets (Target: ≤ 0.3%)				
		ii). Extended spectrum beta-lactamase (ESBL) producers <i>E.coli</i> (Target: ≤ 0.2%)				

		iii). Extended spectrum beta-lactamase (ESBL) producers – <i>Klebsiella pneumonia</i> (target: ≤0.3%)			
		iv). Carbapenem-resistant <i>Enterobacteriaceae</i> (CRE) (target: ≤0.1%)			
		v). <i>Acinetobacter</i> spp (Target: ≤ 0.3%)			
		vi). vancomycin-resistant enterococci (VRE) (Target: ≤ 0.1%)			
		5. Monitoring of AMS indicators			
		a) Percentage of complete antimicrobial prescriptions that contain start date, indication, dosage, route of administration and either duration of therapy or date of next review of the prescription			
		b) Percentage of prescriptions where indications are given and the choice, dose and route of administration of the antimicrobial is in keeping with either National or local antimicrobial guidelines.			
		c) Percentage of antimicrobials started empirically that have a documented review at 72 hours based on updated clinical status and new investigation findings			
		Facility Comments:			
5.5.1.5	The Facility takes appropriate actions on all notifiable emerging and re-emerging diseases and report to the relevant authorities in accordance to regulatory requirement.				
	Note: Prevention and Control of Infectious Diseases Act 1988				
	EVIDENCE OF COMPLIANCE	1. Records and reports on actions taken for all notifiable, emerging and re-emerging diseases that have potential to cause hospital outbreak.			
	Facility Comments:				

5.5.1.6	Feedback on results of safety and performance improvement activities are regularly communicated to the staff and relevant authority.					
	EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff.				
		2. Evidence of feedback via communication on results of performance improvement activities through continuing education activities/meetings.				
		3. Minutes of service/unit/committee meetings				
	Facility Comments:					
5.5.1.7	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.					
	EVIDENCE OF COMPLIANCE	1. Documentation on performance improvement activities and performance indicators.				
		2. Policy statement on anonymity on patients and providers involved in performance improvement activities.				
	Facility Comments:					

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SURVEY ITEM & SELF-ASSESSMENT				
SERVICE STANDARD 06 : PATIENT AND FAMILY RIGHTS				
	<u>PREAMBLE</u> <i>Every patient is unique; with his/her own needs, values and beliefs and religion. Healthcare facilities and services providers need to establish confidence, trust and clear communication with patients and family. Healthcare providers need to understand and protect each patient's and family's cultural and psychosocial beliefs and religion.</i> <i>Outcomes of patient care are safer and much improved when patients and their families or others who make decisions, participate in care decisions and process in a way that meets their expectations.</i> <i>The standards focus on how Patient and Family Rights processes are carried out in the Facility to provide healthcare in an equitable manner considering the delivery system and cost of treatment.</i> <i>The standards also address the rights of patients and families related to research and to the donation and transplantation of organs and tissues.</i>			
<u>TOPIC 6.1:</u> <u>STANDARD 6.1.1</u>	<u>PATIENT AND FAMILY RIGHTS</u> <i>The Facility is responsible for providing processes that support patient and family rights from the point of accessing care.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
6.1.1.1 CORE	The Facility's Management, medical practitioners and other clinical and Allied Health staff work collaboratively to protect and promote Patient and Family Rights. There is documented Patient and Family Rights Policy as identified in relevant laws and regulations that include, but are not limited to: a) access to information on all services provided by the Facility; b) access to safe and medically appropriate treatment regardless of race, culture, sex, nationality, or source of payment; c) access to an interpreter if language barrier exists; d) considerate, respectful, privacy and confidential medical care; e) information of the identity of the medical practitioner and other care givers; f) reasonable information to patient and next of kin about investigations, diagnosis,			

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	treatment and prognosis, including after discharge care and continuity of care and the right to second opinion; g) participation in making informed decisions concerning care through feedbacks (compliment and concern) and grievance mechanism including the right to refuse proposed treatment, experimental care, participation in research projects and the right to leave the Facility against medical advice; h) appropriate counseling prior to being granted discharge from the hospital against medical advice; i) information of applicable and relevant Facility rules and policies; j) administration of pain management where appropriate; k) advice on the approximate cost of treatment prior to the provision of care; l) information regarding financial and other assistance that may be available; m) receipt and examination of an itemised statement of all charges; n) information of the responsibilities of patients and families; o) access to health promotion information to facilitate their treatment in the Facility; p) access to information on quality and performance improvement in the Facility; q) provision of relevant information on the procurement, donation process and transplantation process where necessary.					
	EVIDENCE OF COMPLIANCE				1. There is documented Patient and Family Rights Policy as identified in relevant laws and regulations that address items (a) to (q).	
	Facility Comments:					
6.1.1.2	The Person In Charge (PIC) ensures implementation of Patient and Family Rights in the Facility.					
	EVIDENCE OF COMPLIANCE				1. Job description of PIC related patient's grievance	
					2. Minutes of meetings	
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
6.1.1.3 CORE	Policies and procedures guide the implementation of Patient and Family Rights in the Facility.				
	EVIDENCE OF COMPLIANCE	1. On-site observation on compliance with policies and procedures.			
	Facility Comments:				
6.1.1.4	Staff are educated/trained and knowledgeable about the policies and procedures related to Patient and Family Rights and can explain their responsibilities in protecting patient's rights.				
	EVIDENCE OF COMPLIANCE	1. Records on training programme on Patient and Family Rights			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT							
STANDARD 6.1.2	Care provided is considerate and respectful of the patient's personal values, beliefs and religion. The Facility has a process to respond to patient and family's request for services related to patient's personal values and spiritual beliefs and religion.						
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS			
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
6.1.2.1 CORE	There is a process designed to identify and respect patient's personal values, beliefs and religion and where applicable those of the patient's family.						
	EVIDENCE OF COMPLIANCE	1. Patient's religion and beliefs are identified					
		2. Orientation checklist addresses the needs of patient.					
		Facility Comments:					
6.1.2.2	Staff use the process and provide care that is respectful of the patient's personal values, beliefs and religion.						
	EVIDENCE OF COMPLIANCE	1. Provision of choice of menu					
		2. Information on religious activities, where appropriate.					
		3. Evidence of acknowledgement of patient's special request.					
	Facility Comments:						
6.1.2.3	The Facility responds to routine as well as complex requests related to religious beliefs/support centres.						
	EVIDENCE OF COMPLIANCE	1. Availability of contact number/person of respective religious beliefs/support centres.					
		Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
STANDARD 6.1.3	Care is respectful of the patient's need for privacy especially during clinical interviews, examinations, procedures and treatments. Patient may desire privacy from other staff, other patients or even from family members.					
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
6.1.3.1	There is a process designed for staff to ensure patient's needs for privacy during care and treatment.					
	EVIDENCE OF COMPLIANCE	1. Policy on patient privacy during care and treatment				
		2. On-site observation on compliance with above policy.				
	Facility Comments:					
6.1.3.2	A patient's expressed need for privacy is respected. There is no sharing of rooms during clinical interviews, examinations, procedures and treatments.					
	EVIDENCE OF COMPLIANCE	1. On-site observation on compliance to ensuring patient privacy.				
	Facility Comments:					
6.1.3.3	There is a policy and process for patients who may not wish to be photographed, recorded or participate in interviews, thus staff need to enquire about the patient's privacy needs related to care given.					
	EVIDENCE OF COMPLIANCE	1. Policy on consent for patient to be photographed, recorded or participate in interviews.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
STANDARD 6.1.4	<i>The Facility takes measures to protect patient's possessions from theft or loss. The Facility communicates its responsibility for the patient's personal possessions brought into the Facility. There is a process to account for the possessions and to ensure they will not be lost or stolen. The process considers the possessions of emergency patients, day surgery patients, inpatients, and those patients unable to make alternative safekeeping arrangement and those incapable of making decisions regarding their possessions including those brought in dead.</i>					
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
6.1.4.1 CORE	The Facility has a policy that indicates its responsibility for patient's possessions and a system to ensure this policy is complied with.					
	EVIDENCE OF COMPLIANCE	1. Policy on patients possessions and records				
		2. On-site observation on compliance with the above policy.				
	Facility Comments:					
6.1.4.2	Patients receive information about the Facility's responsibility for safe keeping and protecting personal belongings.					
	EVIDENCE OF COMPLIANCE	1. Orientation checklist and patient/relatives acknowledgement				
		Facility Comments:				
6.1.4.3	Patients' possessions are safeguarded when the Facility assumes responsibility or when a patient is unable to assume responsibility.					
	EVIDENCE OF COMPLIANCE	1. Policy on patients' possessions and records				
		2. On-site observation on compliance to the policy				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
STANDARD 6.1.5	<i>The Facility is responsible for protecting patients from physical injury by outsiders, other patients and staff and patient who are at risk of injuring themselves. Their responsibility is particularly relevant to infants and children, the elderly, disabled individuals, and others at risk. The Facility seeks to prevent injuries through processes such as screening individuals entering the Facility who have no proper identification and monitoring isolated areas of the Facility, as well as being responsive to those thought to be at risk of injury.</i>					
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
6.1.5.1	The Facility has a policy on risk identification and implementation of safety measures to protect patients from injury.					
	EVIDENCE OF COMPLIANCE	1. Policy on risk identification				
		2. Risk identification strategies, e.g. security guard, closed-circuit television (CCTV), fall prevention, schedule of visiting hours and after visiting hours, passes for visitors, etc.				
	Facility Comments:					
6.1.5.2 CORE	Infants, children, the elderly, disabled individuals, and others at risk are addressed in the process as in 6.1.5.1.					
	EVIDENCE OF COMPLIANCE	1. Policy on accompanying relatives				
		2. Evidence of compliance to the policy on risk identification.				
		3. Standard operating procedures on handling of high risk patients.				
		4. Register of visitors after visiting hours for high risk wards/areas.				
	Facility Comments:					
6.1.5.3	Individuals without identification are screened.					
	EVIDENCE OF COMPLIANCE	1. Policy on management of individual without identification				
		2. Facilities for monitoring of high risk/suspected intruders, e.g. security/static guard, CCTV, etc.				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS			
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	Facility Comments:						
6.1.5.4 CORE	Remote and isolated areas of the Facility are monitored.						
	EVIDENCE OF COMPLIANCE	1. Availability of monitoring facilities in remote and isolated areas.					
		2. Records on monitoring/surveillance reports					
	Facility Comments:						

SURVEY ITEM & SELF-ASSESSMENT						
STANDARD 6.1.6	<i>Children, disabled individuals, the elderly and other population at risk receive appropriate protection. Comatose patients and individuals with mental or emotional disabilities are included. Such protection extends beyond physical injury to other areas of safety such as protection from abuse, negligent care, withholding of services or assistance in the event of an evacuation.</i>					
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
6.1.6.1	Children, disabled individuals, the elderly and others identified as vulnerable group are protected from abuse, negligent care, withholding of services or assistance in the event of an evacuation and overall safety of the patients is ensured.					
	EVIDENCE OF COMPLIANCE	1. Policy on protection for children, disabled individuals, the elderly, and others identified as vulnerable group.				
		2. Standard operating procedures for evacuation of the above group during emergencies.				
	Facility Comments:					
6.1.6.2	Special attention and priority care are given to children, disabled individuals, the elderly, individuals with mental and emotional disabilities and other vulnerable groups.					
	EVIDENCE OF COMPLIANCE	1. Policy on provision of priority care for children, disabled individuals, the elderly, individuals with mental and emotional disabilities and other vulnerable groups.				
		2. Orientation for family members and checklists.				
		3. Special amenities provided to meet the needs of the above group, e.g. special lane, disabled friendly toilets, children’s toilets and sink, OKU parking lots with accessibility to wheelchairs, etc.				
		4. On-site observation on compliance to policy for priority care.				
	Facility Comments:					
6.1.6.3	Staff including medical practitioners understand and implement their responsibilities in the protection processes of patients.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Records of orientation/training for in-house staff on the policy.				
		2. On-site observation on practices				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT					
STANDARD 6.1.7	<i>Patient information is kept confidential. Medical and other health information which may be in paper or electronic form or in the combination of both shall be treated as confidential. There are policies and procedures that protect such information by laws from misuse. The policies and procedures also reflect information that is released as required by laws and regulations.</i>				
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
6.1.7.1	Patients are informed about laws and regulations that require the release of and the confidentiality of patient information.				
	EVIDENCE OF COMPLIANCE	1. Policy on release of patient information.			
		2. Patient orientation checklist			
	Facility Comments:				
6.1.7.2	Patients are required to grant permission for the release of information not covered by laws and regulations.				
	EVIDENCE OF COMPLIANCE	1. Signed consent form on release of patient information.			
	Facility Comments:				
6.1.7.3	There is a policy to identify those eligible to receive patient information.				
	EVIDENCE OF COMPLIANCE	1. Policy on release of patient information			
		2. Consent form/authorisation letter			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
6.1.7.4 CORE	The Facility ensures patient health information as confidential.						
	EVIDENCE OF COMPLIANCE	1. Policy on safeguarding of patient information					
		2. Policy on release of patient's medical record.					
		3. Code of conduct of medical records staff					
		4. Secured health information system with restricted access levels					
		5. Restricted access to Medical Records Unit					
		6. System for recording and monitoring movement of medical records.					
		7. Computer-on-wheel/tablets, etc. should be automatically shut-down after 3 minutes when not in used. (should have crossed - reference to Standard 7)					
		8. Policy on no photograph EMR/hardcopy record					
	Facility Comments:						

SURVEY ITEM & SELF-ASSESSMENT						
STANDARD 6.1.8	<i>The Facility supports patients’ and families’ rights to participate in the care process. Patients and families participate in the care process by making decisions about care, asking questions about care, and even refusing diagnostic procedures and treatment.</i>					
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
6.1.8.1	Policies and procedures are developed to support and promote patient and family in care processes including information on medical condition, confirmed diagnosis, planned care and treatment.					
	EVIDENCE OF COMPLIANCE	1. Policy on patient participation in their care and treatment.				
	Facility Comments:					
6.1.8.2 CORE	Patient and the family are informed about the outcomes of care and treatment, including where appropriate the unanticipated outcomes.					
	EVIDENCE OF COMPLIANCE	1. Interview of patient				
		2. Documentation in the medical records				
		3. Consent form where applicable				
	Facility Comments:					
6.1.8.3	Patients are informed about their rights and responsibilities related to refusing or discontinuing treatment and seeking a second opinion.					
	EVIDENCE OF COMPLIANCE	1. Interview of patient				
		2. Orientation checklist				
		3. Documentation in the medical records, e.g. At Own Risk (AOR) discharge form, refusal form, etc.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
6.1.8.4	Staff including medical practitioners are trained on the policies and procedures on their roles and responsibilities in supporting patient and family participation in the care processes.					
	EVIDENCE OF COMPLIANCE	1. Staff orientation/training records				
		2. Minutes of meeting				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
STANDARD 6.1.9	The Facility respects patient's and family's wishes and preferences to withhold resuscitative services within ethical standards.					
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
6.1.9.1	The Facility has an Ethical Committee which documents a policy on withholding resuscitative services which conforms to patient's beliefs, religion and any legal or regulatory requirements.					
	EVIDENCE OF COMPLIANCE	1. Policy on withholding resuscitation				
		2. Minutes of Ethical Committee meeting				
		3. Agenda on Ethics in one of the Facility's committee meeting (non-specialist facility)				
	Facility Comments:					
6.1.9.2	The Facility guides the healthcare professional on the ethical and legal issues in carrying out patient's wishes on withholding resuscitative services in timely manner.					
	EVIDENCE OF COMPLIANCE	1. Policy on withholding resuscitation				
	Facility Comments:					
6.1.9.3	There is documentation about decisions made for withholding resuscitative services.					
	EVIDENCE OF COMPLIANCE	1. Documentation in medical records				
		2. Do Not Resuscitate Consent Form				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
STANDARD 6.1.10	<i>The Facility supports the patient's rights to appropriate assessment and management of symptoms which could have adverse physical and psychological effects.</i>					
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
6.1.10.1	The Facility supports the patient rights to appropriate assessment and management of symptoms.					
	EVIDENCE OF COMPLIANCE	1. Assessment and care plan records.				
	Facility Comments:					
6.1.10.2	Staff including medical practitioners understand the implications of the patient's report of symptoms and accurately assess and manage the symptoms.					
	EVIDENCE OF COMPLIANCE	1. Assessment and care plan records				
		2. Evidence of continuity of care in medical records, including history taking, physical examination, investigations, appropriate treatment given, etc.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT					
STANDARD 6.1.11	<i>The Facility supports the patient's right to humane, respectful and compassionate care at the end of life. Concern for the patient's comfort and dignity during the final stages of life guides all aspects of care. These include treatment of primary and secondary symptoms, pain management, psychological, social, emotional and religious needs.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT SURVEYOR RATING	
6.1.11.1	The Facility recognises and manages the needs of dying patients.				
	EVIDENCE OF COMPLIANCE	1. Policy on end of life care.			
Facility Comments:					
6.1.11.2	Staff including medical practitioners respect and ensure the rights of dying patients to have those needs addressed in the care process.				
	EVIDENCE OF COMPLIANCE	1. Staff orientation			
		2. Availability of contact number/person of respective religious beliefs/support centres			
Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT							
STANDARD 6.1.12	The Facility informs patients and families about its grievance mechanism to receive and act on complaints, conflicts and differences of opinion about care and the patient’s right to participate in these processes.						
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
6.1.12.1 CORE	There is evidence that patients are informed of their rights to voice their complaints and the process to do so.						
	EVIDENCE OF COMPLIANCE	1. Policy on grievance mechanism					
		2. Patient orientation checklist					
		3. Patient Charter					
		4. Brochure on Patient and Family Rights					
	Facility Comments:						
6.1.12.2	There is documented evidence that complaints are reviewed according to the Facility’s grievance mechanism and policy, which include:						
	a) designation of a patient relations officer;						
	b) job description of the patient relations officer;						
	c) decision-making authority given to the patient relations officer;						
	d) how the patient relations officer may be contacted;						
	e) information in the structured orientation programme;						
	f) documentation and revision of all complaints.						
	EVIDENCE OF COMPLIANCE	1. Appointment letter of patient relations officer					
		2. Job description					
		3. Facility directory – contact person to address complaint					
4. Patient orientation checklist							
5. Records of complaints							
Facility Comments:							
6.1.12.3	There is documented procedure to address all grievances which include:						

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS				
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING			
	a) all complaints received are forwarded to the patient relations officer; b) results of the investigations are communicated to the complainant within ten (10) working days.							
	EVIDENCE OF COMPLIANCE	1. Flow chart on grievances mechanism						
		2. Acknowledgement to complainant upon receipt of complaint.						
		3. Results of the investigations are communicated to the complainant within ten (10) working days						
	Facility Comments:							
6.1.12.4	There are documented policies and procedures to identify how the patients and families participate in the grievance process.							
	EVIDENCE OF COMPLIANCE	1. Policies and procedures on participation of patients and families in the grievance process.						
		Facility Comments:						

SURVEY ITEM & SELF-ASSESSMENT							
STANDARD 6.1.13	<u>CONTINUITY OF CARE</u> <i>There is evidence of implementation of the policy on patient's continuity of care including after discharge care.</i>						
6.1.13.1 CORE	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	The Facility ensures that the patient's right to continuity of care is implemented.						
	EVIDENCE OF COMPLIANCE	1. Policy on after discharge care/follow up care					
		2. Appointment system for follow up care					
		3. Home visit where applicable					
		4. Brochure/leaflet on extended care					
Facility Comments:							

SURVEY ITEM & SELF-ASSESSMENT						
STANDARD 6.1.14	PATIENT AND FAMILY EDUCATION <i>The Facility provides an education program that is based on its mission, services provided and patient population and health care practitioners collaborate to provide education. It will involve all department /units.</i>					
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	1. Patient's and family's barriers to learning are assessed and documented. 2. Education by facility staff is provided to patients and families in a manner that accommodates their identified needs					
	EVIDENCE OF COMPLIANCE	1. Education provided to patients and families is documented in the patient medical record 2. Educational pamphlets are developed and is accessible to all 3. There is a process to verify that patients and families receive and understand the education provided				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT				
TOPIC 6.2	<u>INFORMED CONSENT</u> <i>Patients and families are informed as to what tests, procedures and treatments require consent; and how they can give consent, and who may, in addition to the patient, give consent. The consent process is clearly defined and documented in policies and procedures. Relevant laws and regulations are incorporated into the policies and procedures.</i>			
STANDARD 6.2.1	<i>Patient's informed consent is obtained through a process defined by the Facility and carried out by trained medical practitioners.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
6.2.1.1 CORE	There are documented policies and procedures that clearly: a) define informed consent which include the following elements: i) patient's condition ii) proposed treatment (s) or procedure (s) iii) name of the person providing the treatment/procedure iv) potential benefits and drawbacks v) possible alternatives vi) likelihood of success vii) possible problems related to recovery viii) possible results of non treatment b) outline the procedures for obtaining it. Written consent is obtained from: i) the patient; ii) the spouse, parent or next of kin where the patient is mentally disabled; iii) the parent or guardian where the patient is unmarried and below eighteen (18) years of age.			
	EVIDENCE OF COMPLIANCE 1. Policy on informed consent without abbreviation			
	2. Standard Operating Procedures (SOP) on obtaining consent			
	3. Signed consent forms			
	Facility Comments:			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
6.2.1.2	Consent may be dispensed with according to the relevant laws where any delay caused in obtaining the consent would endanger the life of a patient, provided that a consensus of two (2) medical practitioners is obtained and they jointly sign a statement stating that the delay would endanger the life of the patient.				
EVIDENCE OF COMPLIANCE	1. Policy on obtaining consent for life threatening cases that need immediate intervention				
Facility Comments:					
6.2.1.3 CORE	Informed consent is obtained before surgery, anaesthesia, use of blood and blood products, procedure sedation and other high risk treatments and procedures, and the information given shall be documented in the medical records.				
EVIDENCE OF COMPLIANCE	1. Signed consent forms. (The procedure is only performed after the consent taken.)				
	2. Documentation in medical records (explanation given at the time of taking consent)				
	3. Validity of the signed consent form is 30 days				
Facility Comments:					
6.2.1.4	There is a list in the Facility of all types of treatments and procedures that require informed consent.				
EVIDENCE OF COMPLIANCE	1. Approved list of all types of treatments and procedures that require informed consent.				
Facility Comments:					
6.2.1.5	Informed consent is obtained from the patient or family member where applicable by the medical practitioner responsible for the procedures/treatment and risks and				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	complications have been explained to the patient or family members.					
	EVIDENCE OF COMPLIANCE	1. Consent form signed by patient or family member and medical practitioner responsible for the procedures/treatment.				
		2. Interview of patient as observed on-site.				
		3. Documentation in medical records (explanation of risks and complications to the patient or family members.)				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT				
TOPIC 6.3:	RESEARCH <i>A Facility that conducts research, investigations, or clinical trials involving human subjects has a responsibility to the patient's health and well-being. Patients and families will be provided with the following information:</i> a) <i>expected benefits;</i> b) <i>potential risks and complications;</i> c) <i>procedures that shall be followed.</i> <i>All research proposals that involve multicenter trials shall be approved by the Ministry of Health's Medical Research and Ethics Committee.</i>			
STANDARD 6.3.1	<i>A Facility that conducts research, investigations, or clinical trials involving human subjects has a responsibility to the patient's health and well-being.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
6.3.1.1	There is a committee with documented Terms of Reference to oversee all research conducted in the Facility involving human subjects.			
	EVIDENCE OF COMPLIANCE			
	1. Establishment of Research Committee			
	2. Term of Reference			
	3. Minutes of meetings			
	Facility Comments:			
6.3.1.2	The Facility has policies, procedures and code of ethics for the selection and participation of the patient in clinical research, investigation or clinical trials.			
	EVIDENCE OF COMPLIANCE			
	1. Policies and procedures for selection and participation of patients in clinical research, investigation or clinical trials.			
	2. Code of Ethics			
	Facility Comments:			

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
6.3.1.3	The Facility informs patients and families in advance about: a) research procedures; b) risks and benefits; c) obtaining informed consent; d) withdrawal from participation; e) suspension or termination of the research.				
	EVIDENCE OF COMPLIANCE	1. Documentation of (a) to (e) in the patients' medical records			
		2. Samples of patients' participation forms.			
	Facility Comments:				
6.3.1.4	Outcomes of patient who choose to participate in clinical research, investigations or clinical trials are constantly reviewed to protect their well-being and health.				
	EVIDENCE OF COMPLIANCE	1. Periodical report of clinical research related to outcomes of trials.			
		2. Medical records of participating patients.			
	Facility Comments:				
6.3.1.5	Informed consent is obtained before the patient participates in clinical research, investigation or clinical trials.				
	EVIDENCE OF COMPLIANCE	1. Samples of consent forms from participating patients. The informed consent should be taken before the patients participate in the clinical trials.			
		Facility Comments:			

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 6.4:	ORGAN, TISSUE AND CELL DONATION <i>The Facility supports the decision of patients and families to donate organs, tissues and other cell for research or transplantation. Relevant staff of the Facility are made known of policies and procedures on procurement, donation process and the transplantation of organs, tissues and cell.</i>					
STANDARD 6.4.1	<i>Policies and procedures are available to guide the procurement, donation process and the transplantation of organs, tissues and cell. Policies are consistent with relevant laws and regulations and respect the community values, beliefs and religion.</i>					
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
6.4.1.1	The Facility provides relevant information on the procurement, donation process and transplantation process.					
	EVIDENCE OF COMPLIANCE	1. Policy on organ/tissue/cell procurement, donation process and transplantation process (National Policy on Organ Transplantation, Ministry of Health)				
		2. Availability of pamphlets on donation and transplantation of organ.				
	Facility Comments:					
6.4.1.2	There are policies and procedures available to guide the procurement, donation process and the transplantation of organs/tissue/cell, consistent with relevant laws and regulations and respect the individual's values, beliefs and religion.					
	EVIDENCE OF COMPLIANCE	1. Standard operating procedures for procurement, donation process and the transplantation of organs/tissues/cell (National Policy on Organ Transplantation, Ministry of Health)				
	Facility Comments:					
6.4.1.3	Staff are trained in the policies and procedures on organ/tissues/cell donation and					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
CORE	transplantation.					
	EVIDENCE OF COMPLIANCE	1. Availability of trained staff to facilitate the organ, tissue and cell donation and transplantation.				
		2. Staff training records (not less than 20 hours) and certification				
	Facility Comments:					
6.4.1.4	The Facility cooperates with other facilities or agencies responsible for all or a part of the procurement, banking, transportation, and transplantation process.					
	EVIDENCE OF COMPLIANCE	1. Policy on coordination with relevant agencies responsible for all or a part of the procurement, banking, transportation, and transplantation process.				
		2. Staff training log book records				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT				
TOPIC 6.5:	CONSUMER -CENTRED CARE <i>Healthcare service delivery shall focus on intra and cross departmental interactions between individual patients and health care providers. The service arrangements provide opportunity to respond to the inherent complexity of patient's health problems to deliver holistic and needs-focused services. Systems that evolve to embrace coordination of services to be better equipped to respond to these needs.</i>			
STANDARD 6.5.1	<i>The Facility shall make health care systems more responsive to people's needs, while recognising their rights and responsibilities with regard to their own health to promote coordination of health services within the Facility and inter-services collaboration in order to address the patient's multiple co-morbidities and to ensure a holistic approach to patients, including health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services.</i>			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT
				SURVEYOR RATING
6.5.1.1	There shall be inter-services coordination of care for patients with multiple co-morbidities through the alignment and harmonizing of the processes of the different services.			
	EVIDENCE OF COMPLIANCE	1. Cross departmental policy on case management		
	Facility Comments:			
6.5.1.2	The Facility to ensure effective and efficient coordination for patient's requiring multidisciplinary care that include:			
	a) transparent, accessible and understandable service protocols that improve interdisciplinary patient flow; b) appropriate scheduling of appointments; c) reminder notices for specific interventions; d) protocols for referral and discharge.			
	EVIDENCE OF COMPLIANCE	1. Protocols for referral to multidisciplinary team		

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		2. Records on multidisciplinary discussion/patients' related medical records				
		3. Records of patients' notices/reminders				
		4. On-site observation on compliance with protocols for interdisciplinary referral and discharge.				
		Facility Comments:				

SERVICE SUMMARY

SURVEYOR SUMMARY:

OVERALL RATING:

OVERALL RISK:

SURVEY ITEM & SELF-ASSESSMENT			
SERVICE STANDARD 07: HEALTH INFORMATION MANAGEMENT SYSTEM (HIMS)			
	<u>PREAMBLE</u> <i>Patient care services are highly dependent on the communication and transfer of information among healthcare professionals to patients and their families and community. Health information is a resource that shall be managed effectively through:</i> <i>a) identifying information needs;</i> <i>b) developing an information management system;</i> <i>c) defining and capturing data and information;</i> <i>d) analysing data and transforming it into information;</i> <i>e) transmitting and reporting data and information;</i> <i>f) utilisation of information in management decisions.</i> <i>Principles of good information management apply to all methods both paper based or electronic.</i>		
<u>TOPIC 7.1:</u> <u>STANDARD 7.1.1</u>	<u>ORGANISATION AND MANAGEMENT</u> <i>The Health Information Management System (HIMS) Services shall be organised and administered to facilitate the collation, aggregation and analysis of Facility demographic data through an established system which includes confidentiality*, safe keeping and retrieval of medical records and documents both paper based and electronic related to patient care.</i> <i>*Personal Data Protection Act , PDPA 2013</i>		
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT
			SURVEYOR RATING
7.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Health Information Management System Services are clearly documented and measurable. These reflect the roles and aspirations of the		

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.			
	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.			
	2. Goals and objectives of the Health Information Management System Services in line with the Facility statements are available, endorsed and dated.			
	3. Evidence of planned reviews of the above statements.			
	4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc.)			
	5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.			
	Facility Comments:			
7.1.1.2 CORE	There is an organisation chart which: a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head and the staff of the HIMS Services; b) is accessible to all staff and clients; c) is revised when there is a major change in any of the following: i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head of the HIMS Services and staff of the HIMS Services.				
		2. Organisation chart of the service is endorsed, dated and accessible.				
		3. The organisation chart is revised when there is a major change in any of the items (c)(i) to (iv).				
	Facility Comments:					
7.1.1.3	Regular staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the HIMS Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.					
EVIDENCE OF COMPLIANCE	1. Minutes are accessible, disseminated and acknowledged by the staff.					
	2. Attendance list of members with adequate representative of the service.					
	3. Frequency of meetings as scheduled.					
	4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).					
Facility Comments:						
7.1.1.4	The Head of HIMS Services is involved in the planning, justification and management of the budget and resource utilisation of the services.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes of Facility-wide management meeting				
		2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc.) for the service.				
		3. Approved budget and resources.				
	Facility Comments:					
7.1.1.5	The Head of HIMS Services is involved in the appointment and/OR assignment of staff.					
	EVIDENCE OF COMPLIANCE	1. Records on staff interview (if applicable)				
		2. Appointment/assignment letter of Head of Service				
		3. Job description of Head of Service				
		4. Records on staff deployment				
		5. Duty roster				
	Facility Comments:					
7.1.1.6	The HIMS Services plan and design information management processes to meet internal and external information needs.					
	EVIDENCE OF COMPLIANCE	1. Policies and procedures are available to plan and design information management processes.				
		Facility Comments:				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
7.1.1.7 CORE	Statistical information is available from the HIMS Services or elsewhere as determined by the Facility and distributed to appropriate committees and relevant staff. The type and amount of information maintained shall meet the statutory requirements and may include information about major clinical services but not limited to: a) number of admissions and discharges; b) bed occupancy; c) percentage of critical beds occupied; d) patient days; e) births and deaths; f) procedures performed; g) diagnosis in accordance to current ICD (International Classification of Diseases); h) length of stay in days; i) autopsies; j) number of new registrations; k) number of follow up.					
	EVIDENCE OF COMPLIANCE	1. The type and amount of information maintained to meet the statutory requirements include information about major clinical services but not limited to as (a) to (k) should be made available.				
	Facility Comments:					
7.1.1.8	Appropriate statistics and records shall be maintained in relation to the provision of HIMS Services and used for managing the services and patient care purposes.					
	EVIDENCE OF COMPLIANCE	1. Records are available but not limited to the following:				
		a) staffing number and staff profile;				
		b) staff training records;				
		c) number of medical reports produced;				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	d) incident reports;				
	e) other records to be made available, such as:-				
	i) medical reports;				
	ii) data from the Social Security Organisation (SOCSO) /Board;				
	iii) data from Employee Provident Fund (EPF) Board;				
	iv) data from Medical Board;				
	v) medicolegal inquiries;				
	vi) post mortem reports;				
	f) data on performance improvement activities, including performance indicators;				
	g) copy of signatures/signature bank of healthcare providers.				
	Facility Comments:				
7.1.1.9 CORE	A Medical Records Committee chaired by a medical practitioner shall be responsible to:				
	a) determine standards and policies for the HIMS Services;				
	b) introduce new medical record forms or amendments to existing forms;				
	c) recommend actions to be taken to resolve problems related to medical records and the HIMS Services;				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	d) review regularly the contents of medical records to ensure that the recorded clinical information is complete and sufficient for the purpose of providing and evaluating patient care; e) formulate a medical abbreviations list which shall be approved by the Person In Charge (PIC) of the Facility; f) improve HIMS Services. Notes/Explanations Membership of the Medical Records Committee shall be chaired by a medical practitioner and include the Head of HIMS Services, medical and nursing staff representatives, and other healthcare personnel who could contribute substantially to the HIMS Services.			
	EVIDENCE OF COMPLIANCE			
	1. Appointment letters for Chairman and committee members.			
	2. Terms of Reference			
	3. Minutes of meeting			
	4. Medical records audit report			
	5. Current and approved abbreviations list			
	Facility Comments:			
7.1.1.10	There is evidence that the Medical Records Committee meets regularly and keeps adequate minutes which are submitted to the Medical and Dental Advisory Committee (MDAC).			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes of meeting of Medical Records Committee				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT							
<u>TOPIC 7.2</u>		<u>HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT</u>					
<u>STANDARD</u> <u>7.2.1</u>		<i>The HIMS Services shall be directed by and staffed with suitably qualified and trained personnel to achieve the goals and objectives of the services.</i>					
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
7.2.1.1 CORE	The Head and staff of the HIMS Services shall be individuals qualified by education, training, experience and certification to commensurate with the requirements of the various positions.						
	EVIDENCE OF COMPLIANCE	1. Records on credentials of Head of Service and staff required to fill up the posts within the service (to match the complexity of the Facility and services)					
		2. Appointment/assignment letters					
		3. Certification					
		4. Training and competency records					
	Facility Comments:						
7.2.1.2	The authority, responsibilities and accountabilities of the Head of HIMS Services are clearly delineated and documented.						
	EVIDENCE OF COMPLIANCE	1. Appointment/assignment letter for Head of Service.					
		2. Description of duties and responsibilities					
	Facility Comments:						

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
7.2.1.3	Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the need of the services.				
	EVIDENCE OF COMPLIANCE	1. Number of staff and qualification should commensurate with workload.			
		2. Staffing pattern			
		3. Duty roster			
		4. Census and statistics			
	Facility Comments:				
7.2.1.4	There are written and dated specific job descriptions for all categories of staff that include: a) qualifications, training, experience and certification required for the position; b) lines of authority; c) accountability, functions and responsibilities; d) reviewed when required and when there is a major change in any of the following: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (d).				
		2. Job description includes specialisation skills				
		3. Relevant privileges granted where applicable				
		4. The job description is acknowledged by the staff and signed by the Head of Service and dated.				
	Facility Comments:					
7.2.1.5	Personnel records on training, staff development, leave and others are maintained for every staff. Note: <i>Staff personal record may be kept in Human Resource Department as per Facility policy.</i>					
	EVIDENCE OF COMPLIANCE	1. Staff personal records include:				
		a) staff biodata;				
		b) qualification and experience;				
		c) training record;				
		d) competency record and privileging;				
		e) leave record;				
	f) confidentiality agreement.					
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
7.2.1.6	There is a structured orientation programme where new staff are briefed on their services, operational policies and relevant aspects of the Facility to prepare them for their roles and responsibilities.							
	EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme.						
		2. Records on structured orientation programme						
		3. Orientation module						
		4. List of attendance						
	Facility Comments:							
7.2.1.7	Staff receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.							
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff is completed upon probationary period and as an annual exercise.						
	Facility Comments:							
7.2.1.8	There is evidence of training needs assessment and staff development plan which provide the knowledge and skills required for staff to maintain competency in their current positions and future advancement.							
	EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and gaps identified.						
		2. A staff development plan based on training needs assessment is available.						
		3. Training schedule/calendar is in place.						
		4. Training module						

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	Facility Comments:				
7.2.1.9	There are continuing education activities for staff to pursue professional interests and to prepare for current and future changes in practice.				
	EVIDENCE OF COMPLIANCE	1. Training calendar includes in-house/external courses/workshop/conferences			
		2. Contents of training programme			
		3. Training records on continuing education activities are kept and maintained for each staff.			
		4. Certificate of attendance/degree/post basic training .			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT							
<u>TOPIC 7.3:</u>		<u>POLICIES AND PROCEDURES</u>					
<u>STANDARD</u> <u>7.3.1</u>		<i>Written policies and procedures shall reflect current standards of practice for HIMS Services, and they serve as standard operating procedures to meet the information needs of all those providing clinical services, management and external sources that may require data and information from the Facility.</i>					
		CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
7.3.1.1 CORE	There are written policies and procedures for the HIMS Services which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated.						
	There is a mechanism for and evidence of a periodic review at least once in every three years.						
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for the service.					
		2. Policies and procedures are consistent with regulatory requirements and current standard practices.					
		3. Evidence of periodic review of policies and procedures.					
		4. The policies and procedures are endorsed and dated.					
Facility Comments:							
7.3.1.2 CORE	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved. This includes but not limited to:						
	a) information security including data integrity; b) retention time of records, data and information;						

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	c) use of standardised diagnosis codes, procedure codes, symbols, abbreviations and definitions; d) contain sufficient information to identify patients, support diagnosis and treatment, document allergies and the course and outcome of treatment and continuity of care; e) identification of those authorised to make entries in the patient's medical record, with date and time of entry. Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.					
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.				
		2. Minutes of meeting with evidence of cross reference with other departments				
		3. Documented cross departmental policies				
		4. Reference to relevant policies, procedures, protocols, manuals and guidelines, such as Guidelines for Management of Medical Records, Ministry of Health.				
		5. Policies and procedures which include but not limited to (a) to (e).				
		6. Electronic information system security policies				
	Facility Comments:					
7.3.1.3	Current policies and procedures are communicated to all staff.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings				
		2. Circulation list and acknowledgement				
	Facility Comments:					
7.3.1.4 CORE	There is evidence of compliance with policies and procedures.					
	EVIDENCE OF COMPLIANCE	1. Compliance with policies and procedures through:				
		a) interview of staff on practices;				
		b) verify with observation on practices;				
		c) results of medical records audit on practices;				
		d) practices in line with established policies and procedures.				
		e) Audit report on user access for EMR (Reference : GHOP_JCT 2016 Page 50 5.9.3.2 General Condition for Access of EMR in facility)				
	Facility Comments:					
7.3.1.5	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.				
		Facility Comments:				
7.3.1.6	A single record for every patient is maintained with integrated recording system by healthcare providers. A single record is a record that is a composite of all data on a given patient whether as an inpatient, ambulatory care or emergency patient. Their entire medical record is in one folder under one medical record reference number. The record of psychiatric patients shall be retained as according to statutory requirements. Integrated record is a system of joint recording by various healthcare providers who record information around the patient (patient based) according to sequence of events. Notes : For public hospital, option given for single record system : a) Single record (1 patient , 1folder) include Inpatient, Outpatient (Emergency Department, Specialist Clinics, Xray Films and all related document) b) Merging of Inpatient Records from various discipline in One folder c) Merging of outpatient and inpatient records according to discipline in One folder d) Patient Medical Records that has been compiled using methods a or b or c kept in the Medical Records Deptatment, However if there is constraint on storage space the record can be kept at location other than the Medical Records Department with the supervision of Medical Records Officer.Reference : Surat Arahan Kaedah Pemusatan Rekod Perubatan (1 patient 1 folder) 10 Jun 2019					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. A single record system is implemented for inpatient and outpatient.				
		2. Integrated records are practiced.				
	Facility Comments:					
7.3.1.7	There is a system for patient identification, cross referencing and a filing system that allows rapid retrieval of records.					
	EVIDENCE OF COMPLIANCE	1. Policies and procedures for patient identification, cross referencing and a filing system that allows rapid retrieval of records.				
	Facility Comments:					
7.3.1.8	Provision shall be made for 24-hour availability of the patient's record to healthcare providers to ensure continuity of care.					
	EVIDENCE OF COMPLIANCE	1. On-call roster is available for paper based system.				
		2. 24-hour access electronic system to authorised healthcare providers.				
	Facility Comments:					
7.3.1.9 CORE	There is a policy for safeguarding the information in the record against breach of confidentiality, loss, damage, or use by unauthorised personnel.					
	There are policies and procedures on information storage and recovery including procedures for data recovery in case of malfunctions or disaster.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Policy for safeguarding the information in the record against breach of confidentiality, loss, damage, or use by unauthorised personnel is in place.				
		2. Guidelines for management of medical records, electronic information system security and user access control policies (paper based and electronic information systems).				
		3. Mechanisms are in place to support Facility-wide and HIMS functions even in case of unexpected failure or emergency.				
	Facility Comments:					
7.3.1.10	EVIDENCE OF COMPLIANCE	1. Consent form for medical records request is available.				
		2. Signed consent forms				
		3. Authorizations letters				
	Facility Comments:					
7.3.1.11 CORE	The patient's medical record contains documentation of patients' valid consent for all procedures. Written informed consent shall be obtained from: a) the patient; b) the spouse, parent or next of kin where the patient is mentally disabled; c) the parent or guardian where the patient is unmarried and below eighteen years of age.					
	Notes/Explanations					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS			
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	A valid consent may be dispensed with if a surgeon believes that any delay caused in obtaining the consent would endanger the life of a patient, provided that a consensus of the surgeon and another registered medical practitioner is obtained and they jointly sign a statement stating that the delay would endanger the life of the patient.						
	EVIDENCE OF COMPLIANCE	1. Written informed consent is taken in accordance with guidelines and regulatory requirements.					
		2. On-site observation on completeness of consent form.					
	Facility Comments:						
7.3.1.12	Medical records not be removed from the jurisdiction and safekeeping of the Facility unless in accordance with a court order, or statute and this shall be properly recorded. Medical Records can be moved base on cluster framework. A copy of the record shall be retained by the Facility until the original records be returned to the Facility at the end of the proceedings. Notes : Reference : Framework Cluster Hospital 2015						
	EVIDENCE OF COMPLIANCE	1. Policies and procedures on tracing and retrieving of medical records.					
		2. Medical records movement documentation.					
		3. Copy of court order and authorised letter (if applicable).					
	Facility Comments:						
7.3.1.13	There is a system for recording and monitoring movement of medical records within the Facility for easy retrieval.						

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Standard operating procedures for recording and monitoring movement of medical records.				
		2. Movement of medical records is documented.				
	Facility Comments:					
7.3.1.14	The medical practitioners, nurses, and allied health professionals are responsible for the completeness and timely completion of medical records by ensuring the following procedures as stated in the policy manuals:					
		a) clinical history and examination are available within 24 hours of admission and prior to surgical procedures;				
		b) reports of operations or procedures are recorded immediately after completion of the procedure, dated and signed;				
		c) all medical reports shall be completed by medical practitioners within the Facility's stipulated period. Exceptions may occur when test and autopsy reports are not available;				
		d) all records are indexed and coded within one month of the patient's discharge.				
	EVIDENCE OF COMPLIANCE	1. Policies and procedures to include (a) to (d).				
		2. Sampling of patient medical records (BHT)				
		3. Monitoring of timeliness of medical report preparation.				
	Facility Comments:					
7.3.1.15	There is a policy on the retention of medical records and there are guidelines on the appropriate storage of active and inactive records. Records shall be preserved at least for the period as specified under the written law pertaining to limitation period (e.g. Statute of Limitation, National Archives Policy).					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Policy and guidelines on the retention of medical records.				
		2. Records on medical records disposal				
		3. On-site observation on storage of medical records				
	Facility Comments:					
7.3.1.16	There are written policies and procedures to aggregate data and determine what data and information are to be regularly aggregated to meet the needs of clinical and managerial staff in the Facility and agencies outside the Facility.					
	EVIDENCE OF COMPLIANCE	1. Policies, procedures and guidelines on data and information to be collected, analyzed and utilized by the Management.				
		Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT						
<u>TOPIC 7.4:</u>	<u>FACILITIES AND EQUIPMENT</u>					
<u>STANDARD</u> <u>7.4.1</u>	<i>Adequate physical facilities and equipment are available for the efficient operations of the HIMS Services.</i>					
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
7.4.1.1 CORE	The facility for the HIMS Services is designed to facilitate safe and adequate storage, prompt retrieval, distribution and accessibility of medical records.					
	EVIDENCE OF COMPLIANCE	1. On-site inspection of storage areas ensures records are stored safely.				
		2. Preventive measures for possible destruction of records by fire, water and pest.				
		3. Access control for authorised personnel.				
		4. Policy on distribution of medical records addresses the issues of confidentiality and security.				
	Facility Comments:					
7.4.1.2	There are adequate and appropriate facilities and equipment with proper utilisation of space to enable staff to carry out their professional, administrative functions and for other medical personnel to read and work with reference to medical records, including records on microfilm or other storage media.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	EVIDENCE OF COMPLIANCE	1. Adequate and proper utilisation of space for staff functions and medical records storage.					
		2. Appropriate type of equipment/system to match the complexity of services including types of storage media, i.e.microfilm.					
		3. Easy access and clear exit routes					
	Facility Comments:						
7.4.1.3	There is sufficient space for storage needs.						
	a) The active storage area has sufficient space to keep all medical records currently in use at the Facility.						
	b) Inactive records may be stored separately.						
	EVIDENCE OF COMPLIANCE	1. <u>Paper based system</u> On-site observation of the active and inactive medical records storage.					
		2. <u>Electronic system</u>					
		a) Adequate storage space in the server(s)					
		b) Adequate and appropriate space for server.					
		c) Off-site back-up system is available					
Facility Comments:							

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
7.4.1.4	Areas for active and inactive medical records storage are sufficiently secured to protect records against loss, damage or use by unauthorised personnel.							
	EVIDENCE OF COMPLIANCE	1. Access control to areas for active and inactive medical records storage						
		2. Records on medical records movement from the storage areas.						
		3. Appropriate fire suppression system is in place.						
	Facility Comments:							
7.4.1.5	There shall be a system to control the access to the HIMS Services facility.							
	EVIDENCE OF COMPLIANCE	1. Security system to control the access to HIMS Services facility, e.g. closed-circuit television (CCTV), security guard, electronic access system, etc.						
	Facility Comments:							

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 7.5: <u>SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES</u> STANDARD 7.5.1 <i>The Head of HIMS Services shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the HIMS Services.</i>						
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
7.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the HIMS Services. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.					
	EVIDENCE OF COMPLIANCE				1. Planned performance improvement activities include (a) to (f)	
					2. Records on performance improvement activities.	
					3. Minutes of performance improvement meetings	
					4. Performance improvement studies	
					5. Records on innovation if available	
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
7.5.1.2	The Head of HIMS Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement activities to appropriate individual/personnel within the respective services.						
	EVIDENCE OF COMPLIANCE	1. Minutes of meetings					
		2. Letter of assignment of responsibilities					
		3. Job description					
	Facility Comments:						
7.5.1.3	The Head of HIMS Services shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility.						
	Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.						
	EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:					
		a) Training of staff					
		b) Policy on incident reporting					
		c) Methodology of incident reporting					
		d) Register/records of incidents					
		2. Completed incident reports					
		3. Root Cause Analysis					
		4. Corrective and preventive action plans					
		5. Remedial measure					
6. Minutes of meetings							

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
		7. Acknowledgment by Head of Service and PIC/Hospital Director					
		8. Feedback given to staff regarding incident reporting.					
	Facility Comments:						
7.5.1.4 CORE	There is tracking and trending of specific performance indicators not limited to but at least two (2) of the following: a) percentage of medical reports prepared within the stipulated period: Target: 90% Reference: Technical Specifications Of Hospital Performance Indicators For Accountability (HPIA) & Specific Indicators Version 7.1 2019 Secondary and Tertiary Care (Public & Private) Facility: ≤ 4 weeks Primary Care Facility: ≤ 2 weeks) b) Percentage of medical records that were despatched within 72 hours of discharge Target : 95% Reference : National Indicator Approach Version 5.0						
EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored.						
	2. Records on tracking and trending analysis.						
	3. Remedial measures taken where appropriate						
Facility Comments:							

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
7.5.1.5	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.							
	EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff						
		2. Evidence of feedback via communication on results of performance improvement activities through continuing education activities / meetings.						
		3. Minutes of service/committee meetings						
	Facility Comments:							
7.5.1.6	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.							
	EVIDENCE OF COMPLIANCE	1. Documentation on performance improvement activities and performance indicators.						
		2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						
	Facility Comments:							

SURVEY ITEM & SELF-ASSESSMENT						
<u>TOPIC 7.6:</u>	<u>SPECIAL REQUIREMENTS</u>					
<u>STANDARD</u> <u>7.6.1</u>	<i>An accurate patient's medical record is maintained to facilitate optimal patient care and allow for evaluation of the care provided.</i>					
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
7.6.1.1	The patient's medical record contains sufficient details to enable: a) the patient to receive effective continuing care; b) effective communication among the members of the healthcare team; c) medical practitioners to have access to the information required for further consultation and treatment; d) another medical practitioner or other healthcare personnel to assume the care of the patient; e) carrying out concurrent or retrospective evaluation of patient care.					
	<table><tr><td>EVIDENCE OF COMPLIANCE</td><td> 1. Sampling of medical records to ensure (a) to (e) are evidenced in medical records. 2. Audit on quality medical record documentation - sampling is scheduled for at least once in 2 years (Reference: Manual Audit Rekod KKM Terbitan 2018) </td><td></td></tr></table>	EVIDENCE OF COMPLIANCE	1. Sampling of medical records to ensure (a) to (e) are evidenced in medical records. 2. Audit on quality medical record documentation - sampling is scheduled for at least once in 2 years (Reference: Manual Audit Rekod KKM Terbitan 2018)			
EVIDENCE OF COMPLIANCE	1. Sampling of medical records to ensure (a) to (e) are evidenced in medical records. 2. Audit on quality medical record documentation - sampling is scheduled for at least once in 2 years (Reference: Manual Audit Rekod KKM Terbitan 2018)					
	Facility Comments:					
7.6.1.2 CORE	Entries into the records are made only by healthcare professionals of the Facility. Each entry is dated with time and signed by the care provider with name and designation written down.					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Sampling of medical records to validate: a) Only healthcare professionals made entries to the records. b) Each entry is dated with time and signed by the care provider with name and designation written down.			
	Facility Comments:				
7.6.1.3	All entries in the record including alterations to the record shall be legibly written in ink or typewritten or recorded on a computer terminal which is designed to receive such information and if recorded and stored in computer, it may be stored on in any device suitable for the storage of data.				
	EVIDENCE OF COMPLIANCE	1. Sampling of medical records (paper based/electronic system) to be provided by the medical records staff for surveyor's validation.			
	Facility Comments:				
7.6.1.4 CORE	Only the abbreviations and symbols which have been approved by the Medical Records Committee are used.				
	EVIDENCE OF COMPLIANCE	1. Abbreviations and symbols list which have been approved by the Medical Records Committee.			
		2. Sampling of medical records on-site to validate compliance to the abbreviations list.			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
7.6.1.5	All original or copies of reports by medical, nursing and allied health professionals from whatever source of origin are filed in the patient's medical record.					
	EVIDENCE OF COMPLIANCE	1. Completeness of documents in medical records, e.g. laboratory report, reference letter, etc.				
	Facility Comments:					
7.6.1.6	Entries to the medical record shall be timely and made in a way that prevent unauthorised alteration.					
	EVIDENCE OF COMPLIANCE	1. Sampling of medical records on validation of timeliness of entries.				
		2. On-site observation on practices.				
	Facility Comments:					
7.6.1.7	Corrections which are dated and initialed by the author are only made to the medical record by the use of a single line through the incorrect entry. The correction is also put as close to the 'struck out' incorrect entry as possible, indicating that the correction is the intended and correct information. 'White out' or other types of correction materials or erasure of entries shall not be used to correct incorrect entries.					
	EVIDENCE OF COMPLIANCE	1. Policy on correction of wrong entries in medical records				
		2. Sampling of medical records to ensure compliance with the above policy.				
		3. Adequate sampling on the healthcare professional				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT					
STANDARD 7.6.2	Each patient's medical record shall contain appropriate information on the patient and treatment provided.				
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
7.6.2.1	There are adequate particulars to identify the patients: a) a unique medical record number or reference; b) IC or passport number; c) name in full; d) address; e) date of birth; f) gender; g) person and contact details to notify in an emergency.				
EVIDENCE OF COMPLIANCE	1. Sampling of medical records addressing items (a) to (g).				
Facility Comments:					
7.6.2.2	The admission form is completed at the time of admission or when the relevant information is available.				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Sampling of filled admission form			
	Facility Comments:				
7.6.2.3 CORE	An "alert" notation for conditions such as allergic responses and drug reactions shall be documented by the examining doctor and prominently displayed in the medical records and in the appointment card.				
	EVIDENCE OF COMPLIANCE	1. Sampling of medical records to validate entry of alert notation.			
	Facility Comments:				
7.6.2.4	The patient's medical record contains on admission a written provisional diagnosis by the admitting medical practitioner.				
	EVIDENCE OF COMPLIANCE	1. Sampling of medical records for entry of provisional diagnosis where applicable.			
	Facility Comments:				
7.6.2.5	The patient's medical record contains patient's history pertinent to the condition being treated, including relevant details of:				
	a) present and past medical history;				
	b) family history;				
	c) social history and considerations;				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	d) examination; e) assessment including results of investigations; f) observation; g) treatment.				
	EVIDENCE OF COMPLIANCE 1. Sampling of medical records to ensure (a) to (g) are documented in the medical records.				
	Facility Comments:				
7.6.2.6	Drug orders are written directly in the drug prescription form in the patient's medical record by medical practitioners.				
	EVIDENCE OF COMPLIANCE 1. Drug prescription written by medical practitioner.				
	2. Sampling of medical records to verify the above.				
	Facility Comments:				
7.6.2.7	Therapeutic orders and orders for special diagnostic tests are documented in the patient's medical record.				
	EVIDENCE OF COMPLIANCE 1. Sampling of medical records to verify entry of therapeutic orders and orders for special diagnostic tests.				
	Facility Comments:				
7.6.2.8	There is evidence that the care plans are documented in the patient's medical record.				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Sampling of medical records for entry of care plan			
	Facility Comments:				
7.6.2.9	Progress notes, observations and consultation reports are written by medical, nursing, and paramedical staff to record all significant events such as changes in the patient's condition and responses to treatment. These are written as events occur with date and time and give a pertinent chronological report of the patient's progress.				
	EVIDENCE OF COMPLIANCE	1. Chronological integrated notes from medical, nursing and paramedical staff noted in samples of medical records.			
	Facility Comments:				
7.6.2.10	The medical practitioner records the preoperative diagnosis and there is an operative report immediately after surgery, including: a) date, time and duration; b) description of the findings; c) the procedure performed; d) tissue removed; e) tissue sent for pathological examination; f) preoperative and postoperative diagnosis; g) postoperative instructions; h) surgeon's name and signature including name of assistant where applicable.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Sampling of medical records to verify operative report addressing items (a) to (h).				
	Facility Comments:					
7.6.2.11	The patient's medical record contains information particularly relating to anaesthesia including: a) date, time and duration; b) informed consent of anesthesia; c) evidence of a preoperative assessment by an anesthetist, preferably by the attending anaesthetist; d) drugs and doses given during anaesthesia and route of administration; e) monitoring data; f) intravenous fluid therapy, if given; g) post anaesthetic instructions, where appropriate; h) name and signature of attending anaesthetist.					
EVIDENCE OF COMPLIANCE	1. Samplings of medical records and verify the notes containing anaesthetic report addressing items (a) to (h).					
Facility Comments:						
7.6.2.12	All diagnoses and procedures are recorded using relevant terminology of a current revision of the International Classification of Diseases (ICD).					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Sampling of medical records indicating current ICD.			
	Facility Comments:				
7.6.2.13	There is a discharge summary that is completed within 72 hours of the patient's discharge; a copy of which is filed in the patient's medical record. The discharge summary or discharge letter contains at least the following information: a) discharge diagnosis; b) procedures performed; c) follow up arrangements; d) therapeutic orders; e) patient's condition on discharge; f) brief summary of significant findings, results of laboratory tests and events during the patient's hospitalisation. Notes/Explanations The referral letter shall accompany the patient being transferred to another facility with a copy filed in the medical record. For public hospital, only discharge note allowed to be given to patient upon discharge. (Reference : Surat Arahan Bil KKM 87 / P1 /11/(29) Jld 7 bertarikh 12 Nov 2010)				
	EVIDENCE OF COMPLIANCE	1. Sampling of medical records containing discharge summary that address items (a) to (f).			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
7.6.2.14	When an autopsy is performed, a provisional anatomical diagnosis is documented in the patient's medical record within 72 hours and the medical record is completed within one month following the autopsy. A copy of the autopsy report is filed in the medical record.				
	EVIDENCE OF COMPLIANCE	1. Sampling of medical records to verify provisional anatomical diagnosis within 72 hours and completed autopsy report within one month period. Changed to 8 weeks (Refer Surat Pekeliling KPK Bil 17/2008 – Garispanduan Bedah-Siasat Mayat di Hospital-Hospital KKM)			
	Facility Comments:				

SERVICE SUMMARY	
SURVEYOR SUMMARY:	
OVERALL RATING:	
OVERALL RISK:	

SURVEY ITEM & SELF-ASSESSMENT																		
SERVICE STANDARD 08 : EMERGENCY SERVICES																		
	PREAMBLE <i>The Facility shall provide Emergency Services, which shall be accessible and operational on a 24-hour basis. Any individual presenting with perceived or real emergencies arising from any injury or illness has the right to attend the Emergency Services. The Emergency Services shall extend and not refuse care that is deemed clinically necessary to any patient presenting with genuine emergencies to the Emergency Services. The Facility shall identify the scope of Emergency Services to be provided. When or where the services are not available or exceeding its scope, there is a policy regarding referral to a facility equipped with such services to render optimum care to the patient.</i>																	
TOPIC 8.1:	<u>ORGANISATION AND MANAGEMENT</u>																	
STANDARD 8.1.1	<i>The Emergency Services shall provide quality care which shall be organised, directed and coordinated with other services in the Facility according to the goals and objectives of the Facility to meet the needs of the patient population being served.</i>																	
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS															
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING														
8.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Emergency Services are clearly documented and measurable that indicates safety, quality and patient centred care. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff. <table border="1"> <tr> <td rowspan="5">EVIDENCE OF COMPLIANCE</td> <td>1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.</td> <td></td> </tr> <tr> <td>2. Goals and objectives of the Emergency Services in line with the Facility statements are available, endorsed and dated.</td> <td></td> </tr> <tr> <td>3. Evidence of planned reviews of the above statements.</td> <td></td> </tr> <tr> <td>4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)</td> <td></td> </tr> <tr> <td>5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.</td> <td></td> </tr> <tr> <td colspan="2">Facility Comments:</td> <td></td> </tr> </table>	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.		2. Goals and objectives of the Emergency Services in line with the Facility statements are available, endorsed and dated.		3. Evidence of planned reviews of the above statements.		4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)		5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.		Facility Comments:					
EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.																	
	2. Goals and objectives of the Emergency Services in line with the Facility statements are available, endorsed and dated.																	
	3. Evidence of planned reviews of the above statements.																	
	4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)																	
	5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.																	
Facility Comments:																		

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
8.1.1.2 CORE	There is an organisation chart which: a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head of the Emergency Services, consultants, medical practitioners and staff of the Emergency Services; b) is accessible to all staff and clients; c) is revised when there is a major change in any of the following: i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns.			
	EVIDENCE OF COMPLIANCE			
	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head of the Emergency Services, consultants, medical practitioners and staff of the Emergency Services.			
	2. Organisation chart of the service is endorsed, dated and accessible.			
	3. The organisation chart is revised when there is a major change in any of the items (c)(i) to (iv).			
	Facility Comments:			
8.1.1.3	Staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Emergency Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.			
	EVIDENCE OF COMPLIANCE			
	1. Minutes are accessible, disseminated and acknowledged by the staff.			
	2. Attendance list of members with adequate representatives of the service.			
	3. Frequency of meetings are as scheduled.			
	4. Matters requiring action are taken, reported and documented. Pending matters are accounted for and pursued.			
	Facility Comments:			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
8.1.1.4	The Head of the Emergency Services is involved in clinical governance and patient management.					
	EVIDENCE OF COMPLIANCE	1. Appropriate meetings for the department, unit or committee are chaired by Head of Emergency Services.				
		2. Clinical processes are endorsed by the Head of Emergency Services.				
	Facility Comments:					
8.1.1.5	The Head of Emergency Services is involved in the planning, justification and management of the budget and resources of the services.					
	EVIDENCE OF COMPLIANCE	1. Minutes of Facility-wide management meeting.				
		2. Documented evidence on budget and resources (staffing, equipment, etc) request and allocation for the service.				
		3. Approved budget and resources.				
	Facility Comments:					
8.1.1.6	The Head of the Emergency Services is involved in the appointment and/OR assignment of the staff.					
	EVIDENCE OF COMPLIANCE	1. Records on staff interview (if applicable)				
		2. Appointment/assignment letter of Head of Service				
		3. Job description of Head of Service				
		4. Records on staff deployment				
		5. Duty roster				
	Facility Comments:					
8.1.1.7	Appropriate statistics and records shall be maintained in relation to the provision of Emergency Services and used for managing the services and patient care purposes.					
		1. Records are available but not limited to the following:				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	EVIDENCE OF COMPLIANCE	a) workload/census;						
		b) annual report;						
		c) accident/incident reports;						
		d) staffing number and staff profile;						
		e) staff training records;						
		f) data on performance improvement activities, including performance indicators.						
	Facility Comments:							
8.1.1.8	Where the Emergency Services provides clinical experience for students of medicine and paramedical sciences, a comprehensive documented agreement between the Facility and the educational institution shall exist detailing the responsibilities of all parties including: a) time period; b) liability; c) terms of contract review; d) accountability for training and clinical practice.							
EVIDENCE OF COMPLIANCE	1. Valid letter of intent or request/posting and assigned supervisor							
	2. Ratio of Clinical Instructor (CI) and students commensurate with the number of students							
	3. Student allocation roster or programme							
Facility Comments:								

SURVEY ITEM & SELF-ASSESSMENT												
	<u>CONTINUITY OF CARE</u> <i>The department shall provide patient triage, clinical assessment, perform necessary investigation and intervention based on the clinical needs of patient. The emergency care provided will include resuscitation, stabilization and therapeutics. When clinically indicated or the threshold is met, patient shall be referred to other clinical service(s) for further medical care. When definitive care of the patient requires a team approach, the clinical discipline taking a leading patient care role shall be determined by the department. The facility will also ensure the continuity of care is maintained during patient transfer from the emergency department to other parts of the facility.</i> <i>Where the Facility does not have the facilities or medical ability to render optimum care to the patient, arrangements shall be made for transfer to another facility or appropriate treatment centre after initial emergency care.</i>											
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS								
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING							
8.1.2.1 CORE	Where the Facility does not have the facilities or medical ability to render optimum care to the patient, arrangements shall be made for transfer to another facility or more appropriate treatment centre When arranging for patient to be transferred to a receiving facility, there is evidence that: a) communication between the facilities is established by the relevant discipline and the transfer is mutually agreed; b) appropriately qualified staff(s) accompanies the patient; c) relevant patient clinical details is documented, communicated to the accompanying staff and the receiving team; d) continuity of care is ensured throughout this process; <table><tr><td rowspan="3">EVIDENCE OF COMPLIANCE</td><td>1. Copy of referral letter is available.</td><td></td></tr><tr><td>2. Contents in the referral letter are appropriately written and includes acceptance of the patient by the referred facility, name of the receiving person and designation</td><td></td></tr><tr><td>3. Ambulance transfer form, in-transit and hand-over records</td><td></td></tr></table> Facility Comments:		EVIDENCE OF COMPLIANCE	1. Copy of referral letter is available.		2. Contents in the referral letter are appropriately written and includes acceptance of the patient by the referred facility, name of the receiving person and designation		3. Ambulance transfer form, in-transit and hand-over records				
EVIDENCE OF COMPLIANCE	1. Copy of referral letter is available.											
	2. Contents in the referral letter are appropriately written and includes acceptance of the patient by the referred facility, name of the receiving person and designation											
	3. Ambulance transfer form, in-transit and hand-over records											
8.1.2.2	Close working and formal arrangements shall exist between the Emergency Services and appropriate parties: a) Internally with: i) other clinical services of the Facility; ii) support services including cleansing, security;											

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	iii) non-clinical functions of the Emergency Services, i.e. reception, registration/ payment/billing and clerical services. b) Externally with other local healthcare agencies operating within the Facility's catchment area including feeder clinics or facilities.					
	EVIDENCE OF COMPLIANCE	1. Evidence of close working arrangement between the service and other parties such as cross departmental policy, standard operating procedures (SOP), key process(s) of services within the Facility.				
		2. Minutes of meetings or discussions				
		3. Relevant documents on coordination, policy, Memorandum of Understanding or Agreement				
	Facility Comments:					
8.1.2.3	When the ambulance service or other patient transport services is utilised: a) the procedure is done in a coordinated manner; b) medical oversight is provided by the referring facility; c) Continuity of physician directive during the transport is ensured. d) Shall be accompanied by appropriate and competent health care provider					
	EVIDENCE OF COMPLIANCE	1. Ambulance transfer form and records				
		2. Relevant documents on coordination, policy, Memorandum of Understanding or Agreement.				
		3. Validation on continuity of physician's orders during transport from staff interview.				
	Facility Comments:					
8.1.2.4	The Emergency Services shall state its role in internal and external emergency or disaster plans of the Facility (or for the community), e.g. Medical Emergency Team (Code Blue), mass casualty incident.					
	EVIDENCE OF COMPLIANCE	1. Membership in the Facility's risk management and disaster planning committee				
		2. Involvement in the policy and Standard Operating Procedures development for internal and external disasters.				
		3. Incident and disaster drill documentation reports				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	Facility Comments:			

SURVEY ITEM & SELF-ASSESSMENT					
TOPIC 8.2	HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT				
STANDARD 8.2.1	The Emergency Services shall be under the supervision of a registered medical practitioner with training and experience in emergency medicine. It shall be staffed with appropriately qualified and licensed personnel to achieve the goals and objectives of the services.				
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
8.2.1.1 CORE	The Head of the Emergency Services shall be an emergency physician who is a individual qualified by education, training, experience and certification to commensurate with the requirements of the various positions and is NSR (Emergency Medicine) registered.				
	All Emergency Services without resident emergency specialist shall have a visiting Emergency Physician or resident specialist who supervises the Emergency Services.				
	Number / frequency of emergency specialist visit depend on capacity and capability of state determined by head of service of the state or by CEO/PIC				
	EVIDENCE OF COMPLIANCE	1. Records on credentials of Head of Service and staff required to fill up the posts within the service (to match the complexity of the Facility and services) and certification/registration.			
		2. Appointment/assignment letters.			
		3. Certification.			
		4. Training and competency records.			
		5. Valid professional Annual Practising Certificate (APC) and registered with NSR			
		6. Documentation of visits of the Emergency Physician.			
	Facility Comments:				
8.2.1.2	The authority, responsibilities and accountabilities of the Head of Emergency Services are clearly delineated and documented in a letter of appointment.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Appointment/assignment letter for Head of Service.				
		2. Description of duties and responsibilities				
	Facility Comments:					
8.2.1.3	Sufficient numbers of personnel and support staff with appropriate qualifications are employed to enable the services to meet the documented purposes.					
	EVIDENCE OF COMPLIANCE	1. Compliance with norms of current Emergency Medicine Trauma Services Policy of the Ministry of Health where applicable.				
		2. Number of staff and qualification should commensurate with workload.				
		3. Staffing pattern				
		4. Duty roster				
		5. Census and statistics				
	Facility Comments:					
8.2.1.4	There are written and dated specific job descriptions for all categories of staff that include:					
	a) qualifications, training, experience and certification required for the position; b) lines of authority; c) accountability, functions, and responsibilities; d) reviewed when required and when there is a major change in any of the following: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations. e) administrative and clinical functions.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e) for the proper functioning of the Emergency Services.					
		2. Job description includes specialisation skills					
		3. Relevant privileges granted where applicable					
		4. The nature and scope of work of each staff is specified.					
		5. The job description is acknowledged by the staff and signed by the Head of Service and dated.					
	Facility Comments:						
8.2.1.5	Personnel records on training, staff development, leave and others are maintained for every staff. Note: <i>Staff personal record may be kept in Human Resource Department as per Facility policy.</i>						
	EVIDENCE OF COMPLIANCE	1. Staff personal records include:					
		a) staff biodata;					
		b) qualification and experience;					
		c) evidence of current registration;					
		d) training record;					
		e) competency record and privileging;					
		f) leave record;					
	g) confidentiality agreement.						
	Facility Comments:						
8.2.1.6	There are continuing education activities for staff including medical practitioners to pursue professional interests and to prepare for current and future changes in practice.						
	EVIDENCE OF COMPLIANCE	1. Training calendar includes in-house/external courses/ workshop/conferences					
		2. Contents of training programme					
		3. Training records on continuing education activities are kept and maintained for each staff.					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	4. Certificate of attendance/degree/post basic training.				
	Facility Comments:				
8.2.1.7	There is evidence of a training needs assessment and staff development plan which provides the knowledge and skills required for staff to maintain competency in their current positions and future advancement.				
	EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and gaps identified.			
		2. A staff development plan based on training needs assessment is available.			
		3. Training schedule/calendar is in place.			
		4. Training module			
	Facility Comments:				
8.2.1.8	There is a structured orientation programme for all newly appointed staff to the Emergency Services including medical practitioners and for those new to specific areas that include the following: a) explanation of the philosophy, goals, objectives, policies and procedures of the Facility and those of the Emergency Services; b) lines of authority and areas of responsibility; c) explanation of particular duties and functions; d) explanation of the methods of assigning emergency care, and the standards of emergency practice; e) handover communication; f) processes for resolving practice dilemmas; g) information about safety procedures; h) training in basic/ advanced life support techniques; i) methods of obtaining appropriate resource materials; j) staff appraisal procedures for the Emergency Services; k) education on Patient and Family Rights; l) education on MSQH Standards requirements.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme.				
		2. There is Emergency Services orientation programme with relevant topics not limited to topics covered from (a) to (l).				
		3. Attendance list				
	Facility Comments:					
8.2.1.9	Staff including medical practitioners receive written evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.					
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff including medical practitioners is completed and acted upon appropriately upon probationary period and as an annual exercise.				
		Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT								
TOPIC 8.3:		<u>POLICIES AND PROCEDURES</u>						
STANDARD 8.3.1		<i>A reliable and consistent triage system shall be established and used to assess all patients on arrival.</i>						
		CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
8.3.1.1 CORE	Triage shall be performed by a medical practitioner or a paramedical staff trained in triage practice and directs the patient to the appropriate zoning area taking into account the degree of urgency and clinical condition of the patient.							
	EVIDENCE OF COMPLIANCE	1. Triage flow and standard operating procedures (SOP)						
		2. Triage training certificate and log book						
		3. Records on continuing medical education activities for staff.						
	Facility Comments:							
8.3.1.2	The zoning of clinical areas reflective of patient severity/acuity shall be well demarcated and functionally appropriate to the degree of urgency and clinical condition of the patient.							
	EVIDENCE OF COMPLIANCE	1. Zoning of clinical areas is reflective of patient severity/acuity						
		2. Triage category is observed and complied in practice.						
	Facility Comments:							
8.3.1.3	Action plans and policy for the appropriate cohorting, isolation and decontamination of patients suspected or confirm with highly infectious disease or expose to hazardous material shall be available.							
	EVIDENCE OF COMPLIANCE	1. Policy on management of infectious diseases and outbreak in Emergency Services						
		2. Identified areas/structures for cohorting, isolation and decontamination of patients suspected of infectious disease						

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		3. Area use for isolation of patient suspected or confirm with highly infectious disease must be compliance to Infection Prevention and Control (IPC), WHO and engineering requirement by Ministry of Health, Malaysia.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT					
STANDARD 8.3.2	Documented policies and procedures shall reflect current knowledge and evidence based practices for the services; and they are consistent with the objectives of the services and relevant regulations and statutory requirements.				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
8.3.2.1 CORE	There are written policies and procedures for the Emergency Services which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated. There is a mechanism for and evidence of a periodic review at least once in every three years.				
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for the service.			
		2. Policies and procedures are consistent with regulatory requirements and current standard practices.			
		3. Evidence of periodic review of policies and procedures.			
		4. The policies and procedures are endorsed and dated.			
	Facility Comments:				
8.3.2.2	Policies and procedures are developed in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved. Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.				
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.			
		2. Minutes of meeting with evidence of cross reference with other departments			
		3. Documented cross departmental policies			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
8.3.2.3	Current policies and procedures are communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings				
		2. Circulation list and acknowledgement				
	Facility Comments:					
8.3.2.4 CORE	There is evidence of compliance with policies and procedures.					
	EVIDENCE OF COMPLIANCE	1. Compliance with policies and procedures through:				
		a) interview of staff on practices;				
		b) verify with observation on practices;				
		c) results of audit on practices;				
		d) practices in line with established policies and procedures evidenced upon on-site inspection.				
	Facility Comments:					
8.3.2.5	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.					
	EVIDENCE OF COMPLIANCE	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.				
	Facility Comments:					
8.3.2.6	There will be a working relationship between the emergency department and relevant emergency services such as police, fire and rescue, MERS 999, civil defense, other ambulance agencies and/or local disaster agencies etc					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes/report of inter departmental/ inter agency meetings and training: such as disaster table top exercise, interagency life support training etc.				
		2. Shared workflow and standard operating procedures, i.e. for abuse cases under One Stop Crisis Center (OSCC), external and internal disaster response plan and etc.				
	Facility Comments:					
8.3.2.7	All patients shall be correctly identified from arrival at the Emergency Services by use of Health Information Management System including patients unable to provide personal information on their own.					
	EVIDENCE OF COMPLIANCE	1. Patient identification policy, process and workflow				
		2. Patient identification (medical record number)				
		3. Patient identification tag for unconscious and unknown identity patients.				
	Facility Comments:					
8.3.2.8	Where staff provide direct care to patients, documentation is made in the patient's medical record that care has been given. Where appropriate, response to care is recorded by the care provider; signed, dated and designation documented.					
	EVIDENCE OF COMPLIANCE	1. Patient care forms				
		2. Patient medical records				
		3. Drug prescription form				
	Facility Comments:					
8.3.2.9	Seriously ill patients shall have appropriate monitoring, observation with clinical documentation available at all times. There shall be a policy stating which patients shall be admitted and which patients can be observed in the emergency room; and expected duration before patient is admitted, e.g. patients requiring ventilation support, severe burns shall be admitted.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Appropriateness of triage category for seriously ill patient				
		2. Policy for observation and monitoring according to patient severity and care area				
		3. Nursing care notes and documentation				
	Facility Comments:					
8.3.2.10	Appropriate escort personnel and equipment shall follow patient during intra or out of service movements taking into consideration the patient disease or injury severity.					
	EVIDENCE OF COMPLIANCE	1. Standard operating procedures and observation of compliance.				
	Facility Comments:					
8.3.2.11	For Emergency Services having patients intentionally cared in its environment for extended periods, such as dedicated patient observation area or short stay unit, there shall be a documented policy/ guidelines on the operational definitions, clinical criterias, permissible duration of stay and accountability. When admitted patients are unintentionally cared in the Emergency Services environment beyond reasonable period, this is addressed as a situation that is, or will potentially lead to shortfall in care in the facility; notwithstanding, continuity of clinical care is ensured, patient needs and rights are met.					
	EVIDENCE OF COMPLIANCE	1. Policy/ guidelines for observation area/ short stay unit or ward				
		2. Institution policy/standards for unintentional extended stay in the Emergency Services environment				
		3. Length of stay performance / statistics for admitted patient in emergency services; Incident reports for unintentional extended stay				
		4. Patient care documents ie: regularity of doctor review and management, nursing care report incl. vital sign monitoring etc..				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT					
TOPIC 8.4:		FACILITIES AND EQUIPMENT			
STANDARD 8.4.1		Appropriate facilities and lifesaving equipment are available to enable the Emergency Services to meet its goals and objectives to provide safe, effective and efficient emergency care.			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
8.4.1.1	The Emergency Services shall have dedicated treatment zones based on activity. The zone shall be clearly visible with directional signage which is well posted. Access to each area shall be determine it function and maybe restricted from public based on needs. a) Patient drop zone and triage area b) Reception, registration and waiting area c) Resuscitation and critical care area d) Semi-critical area e) Non-critical area f) Procedural and specialty care area for example: plaster room, minor operation theatre and etc. g) Patient isolation and decontamination area h) Others (when applicable) • Ambulance Communication Centre • Ambulance drop zone and access i) Storage (consumable, equipment and disaster) cross reference with standard 2 for disaster, common storage area				
	EVIDENCE OF COMPLIANCE	1. The design and layout of the emergency department shall include features as listed. 2. Policies on access safety and capacity of clinical area. 3. Facility action plan should clinical area exceeds its patient capacity limit at any one time. 4. Patient journey experience (interview)			
Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
8.4.1.2	There are adequate and appropriate facilities and equipment with proper utilisation of space to enable staff to carry out their professional, teaching and administrative functions.					
	EVIDENCE OF COMPLIANCE	1. Adequate and proper utilisation of space.				
		2. Appropriate type of equipment to match the complexity of services.				
		3. Adequate facilities and equipment at each patient care area for safe care. (e.g. defibrillators, emergency cart, hand washing facilities etc.)				
		4. Easy access and clear exit routes				
		5. Absence of overcrowding				
	Facility Comments:					
8.4.1.3	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.					
	EVIDENCE OF COMPLIANCE	1. Testing, commissioning and calibration records (certificates or stickers)				
		2. Certificates of calibration, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc.				
	Facility Comments:					
8.4.1.4 CORE	There is evidence that the facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.					
	EVIDENCE OF COMPLIANCE	1. Planned Preventive Maintenance records such as schedule, stickers, etc.				
		2. Planned Replacement Programme where applicable				
		3. Complaint records				
		4. Asset inventory				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
8.4.1.5	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.					
	EVIDENCE OF COMPLIANCE	1. User training records				
		2. Competency assessment record				
		3. Letter of authorisation				
		4. List of staff trained and authorised to operate specialised equipment				
	Facility Comments:					
8.4.1.6 CORE	The Emergency Services are equipped with the minimum requirements in terms of equipment. Additional equipment may be required to meet the goals and objectives of the Emergency Services and the Facility depending on the level and scope of Emergency Services. Minimum requirements are: <u>Equipment and other functionalities:</u> a) Airway Management devices such as: i) Adjuncts:- oropharyngeal airway, nasopharyngeal airway; ii) Endotracheal Intubation Equipment; iii) Rescue airway devices for Difficult and failed airway situation i.e: supraglottic airway, Video Assisted Laryngoscope and devices. b) Oxygen Delivery Equipment such as; i) various size oxygen mask, simple face mask, venturi mask, high flow rebreathing mask c) Respiratory and ventilation Support such as; i) Ventilator invasive and non-invasive d) Vascular Access Devices and Circulatory Support including: i) Intravascular access devices including intraosseous set (manual/ mechanical) ii) Intravenous fluid delivery devises inclusive volumetric pump and rapid infusions iii) Various intravenous fluids solution for resuscitation and volume replacement. e) Defibrillator and Emergency Cardiac Care Equipment including i) 12 Lead ECG machine and Transcutaneous pacing depending on the level of care provided. ii) Defibrillator with Automated External Defibrillator (AED) capabilities.					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	f) Patient Body Thermal Control Equipment g) Fluid Warmers, Storage for Blood products (depending on level of care; within easy access) h) Limb, Neck and Spine Immobilization and Protection Equipment i) Patient Vital Parameters Monitor including i) Blood Pressure, Pulse Rate, Respiratory Rate, Pulse oxymetry, Cardiac Monitoring and temperature. j) Wounds, Soft tissue and Burns Care Sets k) Point of Care or Bedside (Rapid) Diagnostic Tests or Support including: i) blood sugar analyzer; ii) Urine analyzer. iii) Full blood count iv) Arterial blood gas v) Dengue test l) Bedside Imaging Devices or Support i) Access to portable X-ray; ii) Access to Ultrasound / portable ultrasound / point of care ultrasound m) Emergency Care Equipment for pediatric including length based chart/tape for equipment sizing and emergency drug dosing (Broselow Tape) n) Obstetric Delivery Equipment o) Emergency Patient Care Beds			
	EVIDENCE OF COMPLIANCE 1. On-site observation on availability of items (a) to (o) 2. Credential and privileged medical officer in performing a (iii), d (i), l (ii)			
	Facility Comments:			

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
8.4.1.7 CORE	Medications in formulations or form that reflect current standards and other accepted emergency and resuscitative care best practices, deemed necessary for it to optimally meet goals and objectives of the Emergency Services and the Facility. Minimum requirements are: a) Drugs in Resuscitation Cart but not limited to: i) Oxygen ii) Antianginal – at least Sublingual Glyceryl Trinitrate (GTN) iii) Antiarrhythmics • Adenosine • Amiodarone • Lignocaine • Digoxin iv) Antidotes • Flumazenil • Naloxone v) Atropine vi) Glucose 50% vii) Magnesium Sulphate viii) Calcium Chloride or Gluconate ix) Sodium Bicarbonate x) Adrenaline xi) Water for injection b) Drugs to be kept as floor stock drug with easy availability but not limited to: i) Antihypertensives • ACE inhibitors • Beta Blockers – e.g.: labetalol • Calcium Channel blockers • Angiotensin II Receptor Blockers ii) Activated charcoal iii) Antihistamines • Chlopheniramine • prochlorperazine iv) Antiplatelets • Aspirin			

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	• Clopidogrel v) Bronchodilators : salbutamol/terbutaline, ipratropium bromide (alone and/or combination with salbutamol), Theophylline (aminophylline) and nebuliser preparations vi) Corticosteroids • Hydrocortisone, dexamethasone vii) Inotropic drugs • Dobutamine • Dopamine • Noradrenaline viii) Analgesics • NSAID • OPIOD ix) Anti-Convulsion • Phenytoin sodium • Midazolam • Diazepam • Lorazepam (optional)			
	EVIDENCE OF COMPLIANCE 1. On-site observation on availability of items (a)(i) to (a)(xi) and (b)(i) to (b)(ix)			
	Facility Comments:			

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 8.5:		SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES				
STANDARD 8.5.1		The Head of Emergency Services shall ensure the provision of high quality performance with staff involvement in the ongoing safety and performance improvement activities of the Emergency Services.				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
8.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Emergency Services. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.					
	EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to (f)				
		2. Records on performance improvement activities.				
		3. Minutes of performance improvement meetings				
		4. Performance improvement studies				
		5. Mortality and morbidity audits with remedial actions				
		6. Records on innovation if available				
	Facility Comments:					
8.5.1.2	The Head of Emergency Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement activities to appropriate individual/personnel within the respective services.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes of meetings				
		2. Letter of assignment of responsibilities				
		3. Job description				
	Facility Comments:					
8.5.1.3	The Head of Emergency Services shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility. Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.					
	EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:				
		a) Training of staff				
		b) Policy on incident reporting				
		c) Methodology of incident reporting				
		d) Register/records of incidents				
		2. Completed incident reports				
		3. Root Cause Analysis				
		4. Corrective and preventive action plans				
		5. Remedial measure				
		6. Minutes of meetings				
		7. Acknowledgment by Head of Service and PIC/Hospital Director				
		8. Feedback given to staff regarding incident reporting.				
	Facility Comments:					
8.5.1.4 CORE	There is tracking and trending of specific performance indicators not limited to but at least two (2) of the following including the mandatory indicator: a) <u>Mandatory Indicator</u> percentage of inappropriate triaging (under triaging): Category Green patients who should have been triaged as Category Red (Target: ≤ 0.5%)					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	b) waiting time relative to Triage Category: i) Malaysian Triage Category (MTC) Red seen immediately (Target: 100%) ii) Malaysian Triage Category (MTC) Yellow seen within 30 minutes (Target: ≥85%) iii) Malaysian Triage Category (MTC) Green seen within 90 minutes (> 70%) c) unplanned return of patient seen at Emergency Department within 24 hours for a similar complaint (Target: 3%) as sentinel event.				
	EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored.			
		2. Records on tracking and trending analysis.			
		3. Remedial measures taken where appropriate			
	Facility Comments:				
8.5.1.5	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.				
	EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff.			
		2. Evidence of feedback via communication on results of performance improvement activities through continuing medical education/meetings.			
		3. Minutes of service meetings			
	Facility Comments:				
8.5.1.6	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.				
	EVIDENCE OF COMPLIANCE	1. Documentation on performance improvement activities and performance indicators.			
		2. Policy statement on anonymity on patients and providers involved in performance improvement activities.			
	Facility Comments:				

SURVEYOR SUMMARY:

OVERALL RISK:

SURVEY ITEM & SELF-ASSESSMENT				
SERVICE STANDARD 9 : CLINICAL SERVICES – NON SPECIALIST FACILITY				
	<u>PREAMBLE</u> <i>Clinical Services play an integral role in delivering appropriate care and reducing unwarranted adverse events, as they meet the care people expect to be offered or receive, regardless of where they are treated in the Facility.</i> <i>The Clinical Services shall be organised, directed and coordinated with other services in the Facility to provide a high standard of inpatient and outpatient care to the community and address the following:</i> a) <i>appropriateness of clinical care;</i> b) <i>unwarranted variation in care that is not explained by the clinical circumstances or personal choices of the medical practitioners in:</i> i) <i>overuse of treatments or procedures that do not help patient get better;</i> ii) <i>underuse of care;</i> iii) <i>Misuse (or errors) of doing something incorrectly and harming patients.</i> <i>In addition to the above, the Clinical Services also conduct teaching and training, research and audit activities where applicable.</i>			
<u>TOPIC 9.1:</u> <u>STANDARD 9.1.1</u>	<u>ORGANISATION AND MANAGEMENT</u> <i>The Clinical Services shall be organised, directed and coordinated with other services in the Facility to provide a high standard of inpatient and outpatient care to the community in a safe, efficient, effective, evidence based and caring manner and with due regard for the needs, dignity and privacy of patients and confidentiality of their personal information. The clinical services shall be easily accessible and continuity of care assured.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Clinical Services are clearly documented and measurable that indicates safety, quality and patient centred care. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.				
		2. Goals and objectives of the Clinical Services in line with the Facility statements are available, endorsed and dated.				
		3. Evidence of planned reviews of the above statements.				
		4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)				
		5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.				
	Facility Comments:					
9.1.1.2 CORE	There is an organisation chart which: a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head of Clinical Services, medical practitioners and staff of the Clinical Services; b) is accessible to all staff and clients; c) is revised when there is a major change in any of the following: i) organisation; ii) functions; iii) reporting relationships; iv) Staffing patterns. d) where applicable, the chart should also reflect the clustering hospitals (between Lead & Non Lead)					
	EVIDENCE OF COMPLIANCE	1. Clearly delineated current organisation chart with line of functions and reporting relationships between Person In Charge (PIC), Head of Clinical Services, medical practitioners and staff of the Clinical Services.				
		2. Organisation chart of the service is endorsed, dated and accessible.				
		3. The organisation chart is revised when there is a major change in any of the items (c)(i) to (iv).				
		4. Clustering hospital representation is shown in organization chart				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9.1.1.3	The Governing Body shall ensure that the Clinical Services are organised in such a way as to: a) facilitate the provision of clinical services to patients in the Facility in a safe, efficient, effective and caring manner and with due regard for the needs, dignity and privacy of patients and confidentiality of their personal information; b) assure continuity of care; c) address the professional needs of the medical practitioners; d) ensure that the medical practitioners are involved in the formulation of policies and procedures concerning patient care appropriate to the scope of services of the Facility.				
	EVIDENCE OF COMPLIANCE	1. Departmental/Service operational policies that address (a) to (d).			
		2. Medical Staff By-Laws			
		3. Evidence of involvement of medical practitioners in the formulation of policies and procedures concerning patient care.			
		4. Involvement of Head of the Service in the Clinical Staff Committee and ward meetings.			
		5. Minutes of meetings			
		6. Proper and adequate equipment according to current standards.			
	Facility Comments:				
9.1.1.4	There is a mechanism to ensure effective interaction between the Clinical Services and the Governing Body on all clinical aspects of healthcare and other relevant matters in the Facility. This mechanism is defined in the policies of the Governing Body and is accomplished through: a) the appointment of a medical practitioner(s) as the Head of Clinical Services delineating his/her authority, responsibilities and accountabilities in a written document according to the relevant Acts to manage and control the clinical services; b) Clinical Staff Committee to provide input to the Governing Body on issues related to clinical governance, i.e. planning, coordinating, implementation, control and to improve activities relating to Clinical Services. Note Clinical Staff Committee comprises of medical practitioners from clinical disciplines in the Facility and chaired by the Hospital Director.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Letter of appointment/assignment and delineation of duties and responsibilities of the Head of the Service.				
		2. Letter of appointment and Terms of Reference as member of the Clinical Staff Committee.				
		3. Minutes of meetings				
	Facility Comments:					
9.1.1.5 CORE	The Head of Clinical Services has:					
	a) to be a registered medical practitioner					
	b) representation of the Service in committees and subcommittees where relevant;					
	c) representation of the Service in clinical staff liaison meetings;					
	d) Involvement and provide regular input to the Senior Management Team.					
	EVIDENCE OF COMPLIANCE	1. Letter of assignment from governing body				
		2. Letter of representation of the Head of Service in committees and subcommittees where relevant, e.g. Blood Transfusion Committee, Medical Records Committee, Hospital Infection and Antibiotic Control Committee, etc.				
3. Minutes of meetings of committees						
4. Minutes of meeting of Senior Management Team						
Facility Comments:						
9.1.1.6	The assessment, planning, direction, evaluation and continuity of clinical care are the responsibility of medical practitioners managing individual patients, thus ensuring clinical independence and patient centered care.					
	EVIDENCE OF COMPLIANCE	1. Medical Staff By-Laws; clause indicate clinical care responsibility of medical practitioners.				
		2. Documented evidence of clinical notes in the patient's medical record, e.g. documentation on assessment, planning, direction, evaluation and continuity of clinical care, valid name stamp of medical practitioner.				
		3. Policy and procedures are available to ensure patient centered care				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	Facility Comments:			
9.1.1.7	The Head of Clinical Services shall be involved for the following aspects of management of the services: a) the preparation of budget and ensuring that expenditure remains within the budget allocated; b) human resource management and development; c) development of policies and procedures and ensuring compliance to them; d) facility and equipment management; e) safety and performance improvement activities and risk management.			
	EVIDENCE OF COMPLIANCE	1. Evidence of (a) to (e) in the minutes of meetings of Clinical Services (Senior Management Team) indicate the involvement of Head of Service.		
		2. Endorsement of policies and procedures		
		3. Request for allocation of budget and staffing		
		4. Implementation of performance improvement activities		
		Facility Comments:		
9.1.1.8	Regular staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Clinical Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.			
	EVIDENCE OF COMPLIANCE	1. Minutes are accessible, disseminated and acknowledged by the staff.		
		2. Attendance list of members with adequate representatives of the service.		
		3. Frequency of meetings as scheduled.		
		4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).		
		Facility Comments:		

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9.1.1.9	Appropriate statistics and records shall be maintained in relation to the provision of Clinical Services and used for managing the services and patient care purposes.				
	EVIDENCE OF COMPLIANCE	1. Records are available but not limited to the following: a) workload/census for inpatients and outpatients; b) annual report; c) accident/incident reports; d) staffing number and staff profile; e) staff training records; f) verification of data on performance improvement activities, including performance indicators.			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT				
TOPIC 9.2	<u>HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT</u>			
STANDARD 9.2.1	<u>CREDENTIALING AND PRIVILEGING</u> <i>The Clinical Services shall be directed by a qualified and competent medical practitioner, and staffed by suitably qualified and competent clinical staff to achieve the goals and objectives of the Clinical Services.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9.2.1.1 CORE	There is documented evidence of appropriate training and competency for the granting of clinical privileging. The criteria for determining privileges are specified and documented. There is a structured process to ensure the stated criteria are uniformly applied to all applicants. These include:			
	a) the criteria are designed to assure that patients will receive safe and quality care;			
	b) the criteria for individual procedures are documented in detail, e.g. competency records/log books, application from the individual practitioner, recommendations from peer/referee and minutes of meeting;			
	c) competency for each performance is dated, verified and signed by the supervisors;			
	d) the period of time for which the privileges are to be granted is specified;			
	e) current registration with the local professional registration bodies, e.g. Malaysian Medical Council;			
	f) peer recommendations are taken into account when privileges are being considered;			
	g) the recommendations of the relevant department and/or major professional services for privileges to be granted are taken into consideration.			
	h) All staff under cluster hospital where applicable shall be privileged in the applicable hospital in their respective services			
EVIDENCE OF COMPLIANCE	1. Documented policies and procedures are established to govern the credentialing and privileging processes which include items (a) to (g).			
	2. Compliance with policy and criteria for credentialing and privileging			
	3. Competency records/log books			
	4. Recommendations from peer/referee			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		5. Annual Practising Certificate (APC)				
		6. Privileging certificates which include Lead and Non-lead cluster hospital (where applicable)				
		7. Availability of the list of procedures requiring privileging.				
		8. Availability of list of procedures to include core procedures specific to the disciplines performed by medical officers.				
	Facility Comments:					
9.2.1.2 CORE	Documented evidence of privileges conferred by the Governing Body is available and accessible to relevant staff at point of care.					
	EVIDENCE OF COMPLIANCE	1. Formal letter of assignment or certificate of privileging with stipulated timeline are issued and reviewed accordingly.				
		2. Updated list of staff with privileges conferred is made accessible at point of care.				
	Facility Comments:					
9.2.1.3	Clinical staff performs within the privileges conferred.					
	EVIDENCE OF COMPLIANCE	1. Verification of procedures performed by individuals at point of care within the awarded privileging rights with evidence of:				
		a) list of procedures privileged;				
		b) operating list;				
		c) operating notes/clinical notes.				
	Facility Comments:					
9.2.1.4	There are written and dated specific job descriptions for all categories of staff that include:					
	a) qualification, training, experience and certification required for the position;					
	b) lines of authority;					
	c) accountability, functions, and responsibilities;					
	d) reviewed when required and when there is a major change in any of the following;					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations. e) administrative and clinical functions.					
	EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e).				
		2. Job description includes specialisation skills				
		3. Relevant privileges granted where applicable				
		4. The job description is acknowledged by the staff and signed by the Head of Service and dated.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT							
STANDARD 9.2.2	STAFF TRAINING, EDUCATION, APPRAISAL AND RESEARCH The Facility and all staff shall demonstrate an ongoing commitment to continuing medical education						
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9.2.2.1	The facility shall establish a Competency Development Framework (CDF) which is consistent with the service to be provided and delivered in order to achieve a quality and safe care.						
	EVIDENCE OF COMPLIANCE	1. A Competency Development Framework checklist					
		2. The checklist should address the adequacy & appropriateness of staff education , training & experience					
		Facility Comments:					
9.2.2.2 CORE	There is evidence of training needs assessment and staff development plan which provide the knowledge and skills required for staff to maintain competency in their current positions and future advancement.						
	EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and gaps identified.					
		2. A staff development plan based on training needs assessment is available.					
		3. Training schedule/calendar is in place.					
		4. Training module					
	Facility Comments:						
9.2.2.3	There are continuing education activities for staff including medical practitioners to pursue professional interests and to prepare for current and future changes in practice.						
	EVIDENCE OF COMPLIANCE	1. Training calendar include in-house/external courses/ workshop/conferences					
		2. Contents of training programme					
		3. Training records on continuing education activities are kept and maintained for each staff including training in life support.					
		4. Certificate of attendance/degree/post basic training.					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	Facility Comments:			
9.2.2.4	The educational needs of staff and the Facility, as evidenced by the results of medical-care evaluation such as incident reports, performance improvement studies and complaints, are taken into consideration when the content and structure of educational activities are planned. EVIDENCE OF COMPLIANCE 1. Evidence of inclusion of results of audit activities, e.g. mortality and morbidity reviews, incident reporting, etc in educational activities. 2. Evidence of improvement made from corrective or preventive measures from incident reports. Facility Comments:			
9.2.2.5	Staff including medical practitioners receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility. EVIDENCE OF COMPLIANCE 1. Performance appraisal for staff including medical practitioners is completed upon probationary period and as an annual exercise. Facility Comments:			
9.2.2.6	The Facility shall ensure that the staffs are trained in aspect of patient centered care EVIDENCE OF COMPLIANCE 1. Documented evidence of training. Facility Comments:			
9.2.2.7	Where appropriate the Facility shall endeavour to undertake clinical research using available resources			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Documented evidence of research activities, e.g. protocol, policies, consent, etc.				
	Facility Comments:					

SURVEY ITEM &SELF-ASSESSMENT					
STANDARD 9.2.3		<u>STAFFING LEVEL AND STAFF COMPETENCY</u> <i>The Head and staff of the Clinical Services including medical practitioners are individuals qualified by education, training and experience commensurate with the requirements of the various positions and relevant laws.</i>			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9.2.3.1	Deployment of all service providers for any clinical service takes the following factors into consideration: a) the number of persons deployed is proportional to the number of patients being cared for as in the regulatory requirements and for the intensity of care provided; b) the categories of service providers based on qualifications and experience providing care reflect the complexity of clinical problems being managed; c) staffing needs shall take into consideration absences due to leave or illness; double shift duties by clinical staff shall be documented and monitored; d) adequate staffing levels of appropriate competency shall be maintained throughout the hours the services are in operation. Where services need to be provided on a 24-hour basis, staffing level reflects the intensity of activities during each shift; e) where it is not possible to have service providers on duty on site, e.g. after working hours, provision is made for relevant medical practitioner to be available on call.				
	EVIDENCE OF COMPLIANCE	1. Documentation and planning on deployment of staff that includes but not limited to (a) to (e) with evidence of:			
		i) deployment based on staff to patient ratio, bed occupancy rate and complexity of cases;			
		ii) special skills/training of staff;			
		iii) contingency plan during acute shortage;			
		iv) duty roster.			
	Facility Comments:				

SURVEY ITEM &SELF-ASSESSMENT											
STANDARD 9.2.4	STAFF ORIENTATION <i>A structured orientation programme introduces new staff to their services, operational policies and relevant aspects of the Facility to prepare them for their roles and responsibilities.</i>										
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS								
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING							
9.2.4.1	There is a structured orientation programme for all newly appointed staff to the Clinical Services including medical practitioners and for those new to specific areas that include the following: a) explanation of the goals, objectives, policies and procedures of the Facility and those of the Clinical Services; b) lines of authority and areas of responsibility; c) explanation of particular duties and functions; d) explanation of the methods of assigning clinical care and the standards of clinical practice; e) handover communication; f) processes for resolving practice dilemmas; g) information about safety procedures; h) training in basic/advanced life support techniques; i) methods of obtaining appropriate resource materials; j) staff appraisal procedures for the Clinical Services; k) education on Patient and Family Rights; l) education on MSQH Standards requirements.										
	<table><tr><td rowspan="3">EVIDENCE OF COMPLIANCE</td><td>1. Policy requiring all new staff to attend a structured orientation programme.</td><td></td></tr><tr><td>2. There is Clinical Services orientation programme with relevant topics not limited to topics covered from (a) to (l).</td><td></td></tr><tr><td>3. Attendance list</td><td></td></tr></table>	EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme.		2. There is Clinical Services orientation programme with relevant topics not limited to topics covered from (a) to (l).		3. Attendance list				
EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme.										
	2. There is Clinical Services orientation programme with relevant topics not limited to topics covered from (a) to (l).										
	3. Attendance list										
	Facility Comments:										

SURVEY ITEM &SELF-ASSESSMENT							
TOPIC 9.3		<u>POLICIES AND PROCEDURES</u>					
STANDARD 9.3.1		<u>DEVELOPMENT, DERIVATION AND DOCUMENTATION</u> <i>There are written and dated policies and procedures for all activities of the Clinical Services. These policies and procedures reflect current standards of medical practice, relevant regulations, statutory requirements and the purposes of the services. These policies and procedures, terms of reference, by-laws, rules or regulations state how the clinical staff including medical practitioners regulate themselves and provide patient care.</i>					
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS			
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
9.3.1.1 CORE	There are written policies and procedures for the Clinical Services which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated. There is a mechanism for and evidence of a periodic review at least once in every three years.						
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for the service.					
		2. Policies and procedures are consistent with regulatory requirements and current standard practices.					
		3. Evidence of periodic review of policies and procedures.					
		4. The policies and procedures are endorsed and dated.					
	Facility Comments:						
9.3.1.2	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved. Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.						
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.					
		2. Minutes of meeting with evidence of cross reference with other departments					
		3. Documented cross departmental policies					
	Facility Comments:						

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9.3.1.3 CORE	The policies and procedures documentation shall address at least the following topics and any others required by relevant standards and laws: a) description of the organisational structure of the Clinical Services; b) clinical practice guidelines; c) clinical documentation includes pain as the 5 th vital sign where appropriate; d) handover communication; e) drug prescription, dispensing and administration; f) blood transfusion; g) continuing of care including regular review of patient, review of investigation results, discharge [planned or At Own Risk (AOR)], referrals and escort as necessary; h) pain management; i) management of patients under police custody/prisoner; j) management of cases with an infectious disease including notification of notifiable diseases. k) the responsibilities of the staff including medical practitioners in relation to internal and external disasters are documented, and known to the staff (contingency plan); l) incident reports shall be compiled, investigated, discussed, and recorded and action plans implemented; m) end of life care; n) management of a death.				
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures that address but not limited to (a) to (n).			
	Facility Comments:				
9.3.1.4	Current policies and procedures are communicated to all staff.				
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings			
		2. Circulation list and acknowledgement			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9.3.1.5 CORE	There is evidence of compliance with policies and procedures.					
	EVIDENCE OF COMPLIANCE	1. Compliance with policies and procedures through:				
		a) interview of staff on practices;				
		b) verify with observation on practices;				
		c) results of audit on practices;				
		d) practices in line with established policies and procedures.				
	Facility Comments:					
9.3.1.6	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.					
	EVIDENCE OF COMPLIANCE	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.				
		Facility Comments:				
9.3.1.7	The services shall operate on a 24-hour basis providing a level of care appropriate to the activities of the patients in the Facility.					
	EVIDENCE OF COMPLIANCE	1. Operational policy on 24-hour services				
		2. Staffing level reflects good mix of experienced staff and the intensity of activities during each shift.				
		3. On-call roster is dated and authorised.				
		Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT					
TOPIC 9.4:	<u>FACILITIES AND EQUIPMENT</u>				
STANDARD 9.4.1	<i>The Head of Clinical Services shall ensure adequate facilities and equipment that are safe and appropriate are available for the staff to function effectively and to meet the goals and objectives of the Clinical Services.</i>				
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT
					SURVEYOR RATING
9.4.1.1	There are adequate and appropriate facilities and equipment with proper utilisation of space to enable staff to carry out their professional, teaching and administrative functions.				
	EVIDENCE OF COMPLIANCE	1. Adequate and proper utilisation of space			
		2. Appropriate type of equipment to match the complexity of services.			
		3. Adequate facilities and equipment at each patient care area for safe care. (e.g. defibrillators, emergency cart, hand washing facilities, etc)			
		4. Easy access and clear exit routes			
		5. Absence of overcrowding			
	Facility Comments:				
9.4.1.2	Existing facilities shall take cognisance of the safety of staff and patients.				
	EVIDENCE OF COMPLIANCE	1. Design and layout of the unit, e.g. wards, treatment rooms, dirty and clean utility rooms, access, lighting, signage, etc address the safety aspects of patients and staff.			
		2. Adequate equipment and supplies for Clinical Services, e.g. emergency trolley, functioning patient call bell, etc.			
		3. Equipment should have scheduled planned preventive maintenance (PPM).			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9.4.1.3	Suitable and adequate forms of communication and intercommunication systems and equipment are provided to enable clinical staff to communicate among themselves and with the other members of the healthcare team.				
	EVIDENCE OF COMPLIANCE	1. Appropriate telecommunication modalities available for daily operation and during emergencies.			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT					
STANDARD 9.4.2	<u>FACILITIES AND EQUIPMENT FOR PATIENT CARE</u> <i>Adequate facilities and equipment shall be available to provide safe and effective patient care.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9.4.2.1	Facilities are suitably located to facilitate easy access and to provide an atmosphere of user, environmental and 'disabled' friendly.				
	EVIDENCE OF COMPLIANCE	1. Floor plan indicates accessibility and patient and user friendly.			
		2. Feedback from patient satisfaction survey			
		3. Incident reporting relating to facilities if any.			
	Facility Comments:				
9.4.2.2 CORE	Equipment, both for emergency and non-emergency usage, shall be appropriate to the level of care.				
	EVIDENCE OF COMPLIANCE	1. Availability of emergency and non-emergency equipment appropriate to level of care, such as defibrillator, emergency trolley (adults and children), suction machine, electrocardiogram (ECG) machine, infusion or syringe pump, vital sign monitor, etc.			
		2. Scheduled checking of items in emergency trolley			
	Facility Comments:				
9.4.2.3	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.				
	EVIDENCE OF COMPLIANCE	1. Testing, commissioning and calibration records (certificates or stickers)			
		2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as evidence of compliance to the relevant standards and Acts.			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9.4.2.4 CORE	There is evidence that the facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.				
	EVIDENCE OF COMPLIANCE	1. Planned Preventive Maintenance records, such as schedule, stickers, etc.			
		2. Planned Replacement Programme where applicable			
		3. Complaint records			
		4. Asset inventory			
	Facility Comments:				
9.4.2.5	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.				
	EVIDENCE OF COMPLIANCE	1. User training records			
		2. Competency assessment record			
		3. Letter of authorisation			
		4. List of staff trained and authorised to operate specialised equipment			
	Facility Comments:				
9.4.2.6	Equipment is upgraded (based on evidence) from time to time so as to keep pace with advancement in operative and diagnostic techniques and technology.				
	EVIDENCE OF COMPLIANCE	1. Equipment are being replaced and upgraded to meet current standard of care and advancement in technology in a planned and systematic manner.			
	Facility Comments:				

SURVEY ITEM &SELF-ASSESSMENT						
STANDARD 9.4.3		<u>FACILITIES FOR CLINICAL OUTPATIENT SERVICES</u> <i>Where visiting specialists or outpatient services are provided, there are adequate outpatient clinics to enable the provision of safe and effective patient care; and patient privacy and confidentiality are assured.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9.4.3.1	The Visiting Specialist or Outpatient Services shall have the following features: a) the organisation and management of the clinics are planned so as to ensure prompt attention to patients, minimal waiting time, and avoidance of unnecessary visits by the patients; b) record keeping shall be efficient; c) an appointment or queuing system is used to manage patient consultations; d) the clinic is easily accessible including for non-ambulant patients and is easily identified through adequate signage; e) the clinic is located close to other facilities, e.g. radiology, laboratories and pharmacy; f) adequate provision is made for patient comfort.					
	EVIDENCE OF COMPLIANCE	1. The Visiting Specialist or Outpatient Services address (a) to (f) with evidence of but not limited to the following:				
		a) list of services available and offered to patients;				
		b) flow chart on work process;				
		c) safe keeping of medical records;				
		d) security of data in Health Information System;				
		e) clinic appointment system;				
		f) monitoring of waiting time;				
		g) adequate and appropriate signage;				
		h) floor plan indicates accessibility to supporting services and optimisation of space;				
		i) adequate patient personal use items, e.g. wheelchair, etc;				
		j) adequate waiting area, rest rooms, refreshments, reading material and parking space.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 9.5:	<u>SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES</u>					
STANDARD 9.5.1	<i>The Head of Clinical Services shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Clinical Services. The Head of Clinical Services shall ensure compliance to monitoring of specific performance indicators.</i>					
	CRITERIA FOR COMPLIANCE:	SELF RATING	AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
9.5.1.1 CORE	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Clinical Services. The process includes:					
	a) Planned activities					
	b) Data collection					
	c) Monitoring and evaluation of the performance					
	d) Action plan for improvement					
	e) Implementation of action plan					
	f) Re-evaluation for improvement					
	Innovation is advocated.					
EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to (f)					
	2. Records on performance improvement activities					
	3. Minutes of performance improvement meetings					
	4. Performance improvement studies					
	5. Mortality and morbidity audits with remedial actions					
	6. Records on innovation if available.					
Facility Comments:						

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9.5.1.2	The Head of Clinical Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement activities to appropriate individual/personnel within the respective services.			
	EVIDENCE OF COMPLIANCE			
	1. Minutes of meetings			
	2. Letter of assignment of responsibilities			
	3. Job description			
	Facility Comments:			
9.5.1.3	The Head of Clinical Services shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility.			
	Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.			
	EVIDENCE OF COMPLIANCE			
	1. System for incident reporting is in place, which include:			
	a) Training of staff			
	b) Policy on incident reporting			
	c) Methodology of incident reporting			
	d) Register/records of incidents			
	2. Completed incident reports			
	3. Root Cause Analysis			
	4. Corrective and preventive action plans			
	5. Remedial measure			
	6. Minutes of meetings			
	7. Acknowledgment by Head of Service and PIC/Hospital Director			
	8. Feedback given to staff regarding incident reporting.			
	Facility Comments:			

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
9.5.1.4 CORE	The staff including medical practitioners provide an appropriate peer group structure for performing the safety and performance improvement activities to accomplish clinical care evaluation. a) The medical practitioners undertake clinical reviews of all risk assessments, incident reports, audits and safety and performance improvement activities: i) as a single committee for all safety and performance improvement activities; ii) in a variety of purpose-specific committees, such as mortality and morbidity, blood transfusion and infection control. b) Whatever structure is utilised, provision is made for review and analysis of the clinical work of the service. c) Clinical service to provide input periodically to the Governing Body on the safety and performance improvement activities.					
	EVIDENCE OF COMPLIANCE	1. Performance improvement activities				
		2. Minutes of meetings				
		3. Relevant reports and documents, e.g. clinical audit reports, incident reports, mortality and morbidity review reports, etc				
	Facility Comments:					
9.5.1.5 CORE	There is tracking and trending of specific performance indicators not limited to but at least two (2) of the following: a) number of mortality/morbidity audits/meetings being conducted in the department with documentation of cases discussed b) percentage of unplanned re-admission within 72 hours of discharge c) case fatality rate for two diseases (Facility to decide based on local disease prevalence) d) notification of infectious disease within stipulated period of time					
	EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored.				
		2. Records on tracking and trending analysis.				
		3. Minutes of mortality/morbidity audits meetings				
		4. Remedial measures taken where appropriate				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9.5.1.6	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.					
	EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff.				
		2. Evidence of feedback via communication on results of performance improvement activities through continuing medical education/meetings.				
		3. Minutes of service/unit/committee meetings				
	Facility Comments:					
9.5.1.7	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.					
	EVIDENCE OF COMPLIANCE	1. Documentation on performance improvement activities and performance indicator activities.				
		2. Policy statement on anonymity on patients and providers involved in performance improvement activities.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT																		
TOPIC 9.6: STANDARD 9.6.1	<u>SPECIAL REQUIREMENTS</u> <u>CONTINUITY OF CARE</u> <i>There shall be bi-directional line of care involving specialist and non specialist facility where appropriate level of care and optimum care to the patient is provided.</i>																	
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS															
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING														
9.6.1.1	Where the Facility's infrastructure or clinical response/level of care is does not commensurate with the patient's level of care required, arrangements shall be made for transfer to another facility or appropriate treatment centre <table border="1"> <tr> <td rowspan="4">EVIDENCE OF COMPLIANCE</td> <td>1. Documented policies and procedures are established to govern the arrangement of different categories of patient transfer</td> <td></td> </tr> <tr> <td>2. Referral letter is available.</td> <td></td> </tr> <tr> <td>3. Contents in the referral letter are appropriately written and includes acceptance of the patient by the referred facility, name of receiving person</td> <td></td> </tr> <tr> <td>4. Ambulance transfer and in-transit records</td> <td></td> </tr> <tr> <td colspan="3">Facility Comments:</td> </tr> <tr> <td colspan="3"></td> </tr> </table>	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures are established to govern the arrangement of different categories of patient transfer		2. Referral letter is available.		3. Contents in the referral letter are appropriately written and includes acceptance of the patient by the referred facility, name of receiving person		4. Ambulance transfer and in-transit records		Facility Comments:							
EVIDENCE OF COMPLIANCE	1. Documented policies and procedures are established to govern the arrangement of different categories of patient transfer																	
	2. Referral letter is available.																	
	3. Contents in the referral letter are appropriately written and includes acceptance of the patient by the referred facility, name of receiving person																	
	4. Ambulance transfer and in-transit records																	
Facility Comments:																		

SURVEY ITEM &SELF-ASSESSMENT																	
STANDARD 9.6.2	<u>WHO GLOBAL SURGERY INITIATIVE</u> <i>The WHO Global Surgery Initiative is organised to provide safe and efficient care for patients. The WHO Global Surgery Initiative is coordinated with other departments and services of the Facility. The service could also include patients treated and managed for medical conditions, diagnostic and interventional procedures.</i>																
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS														
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING													
9.6.2.1	The Governing Body shall ensure that WHO Global Surgery Initiative is organised in such a way as to: a) facilitate the provision of surgical services to patients in the Facility in a safe, efficient, effective, and caring manner and with due regard for the needs, dignity and privacy of patients and confidentiality of their personal information; b) assure continuity of care; c) address the professional needs of the medical practitioners; d) ensure that the medical practitioners are involved in the formulation of policies and procedures concerning patient care appropriate to the scope of services of the Facility.																
	<table><tr><td rowspan="6">EVIDENCE OF COMPLIANCE</td><td>1. Departmental/Service operational policies that address (a) to (d).</td><td></td></tr><tr><td>2. Medical Staff By-Laws</td><td></td></tr><tr><td>3. Evidence of involvement of medical practitioners in the formulation of policies and procedures concerning patient care.</td><td></td></tr><tr><td>4. Involvement of Head of the Service in the Medical Advisory Committee /Medical Staff Committee and ward meetings.</td><td></td></tr><tr><td>5. Minutes of meetings</td><td></td></tr><tr><td>6. Proper and adequate equipment according to current standards.</td><td></td></tr></table>	EVIDENCE OF COMPLIANCE	1. Departmental/Service operational policies that address (a) to (d).		2. Medical Staff By-Laws		3. Evidence of involvement of medical practitioners in the formulation of policies and procedures concerning patient care.		4. Involvement of Head of the Service in the Medical Advisory Committee /Medical Staff Committee and ward meetings.		5. Minutes of meetings		6. Proper and adequate equipment according to current standards.				
EVIDENCE OF COMPLIANCE	1. Departmental/Service operational policies that address (a) to (d).																
	2. Medical Staff By-Laws																
	3. Evidence of involvement of medical practitioners in the formulation of policies and procedures concerning patient care.																
	4. Involvement of Head of the Service in the Medical Advisory Committee /Medical Staff Committee and ward meetings.																
	5. Minutes of meetings																
	6. Proper and adequate equipment according to current standards.																
	Facility Comments:																

SERVICE SUMMARY	
SURVEYOR SUMMARY:	
OVERALL RATING:	
OVERALL RISK:	

SURVEY ITEM & SELF-ASSESSMENT	
SERVICE STANDARD 9A: CLINICAL SERVICES - MEDICAL RELATED SERVICES	
	<u>PREAMBLE</u> <i>Medical Services play an integral role in delivering appropriate care and reducing unwarranted adverse events, as they meet the care people expect to be offered or receive, regardless of where they are treated in the Facility.</i> <i>The Medical Services shall be organised, directed and coordinated with other services in the Facility to provide a high standard of inpatient and outpatient care to the community and cover the following:</i> <i>a) appropriateness of clinical care;</i> <i>b) unwarranted variation in care that is not explained by the clinical circumstances or personal choices of the medical practitioners in:</i> <i>i) overuse of treatments or procedures that do not help patients get better;</i> <i>ii) underuse of care;</i> <i>iii) misuse (or errors) of doing something incorrectly and harming patients.</i> <i>In addition to the above, the Medical Services also conduct teaching and training, research and audit activities where applicable.</i>
<u>TOPIC 9A.1:</u> <u>STANDARD 9A.1.1</u>	<u>ORGANISATION AND MANAGEMENT</u> <i>The Medical Services shall be organised, directed and coordinated with other services in the Facility to provide a high standard of inpatient and outpatient care to the community in a safe, efficient, effective, evidence based and caring manner and with due regard for the needs, dignity and privacy of patients and confidentiality of their personal information. The Medical Services shall be easily accessible and continuity of care assured.</i>

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9A.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Medical Services are clearly documented and measurable that indicates safety, quality and patient centred care. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.				
	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.			
		2. Goals and objectives of the Medical Services in line with the Facility statements are available, endorsed and dated.			
		3. Evidence of planned reviews of the above statements.			
		4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)			
		5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.			
	Facility Comments:				
9A.1.1.2 CORE	There is an organisation chart which: a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head of Medical Services, consultants, medical practitioners and staff of the Medical Services; b) reflect the relevant medical subspecialties services/units; c) is accessible to all staff and clients; d) is revised when there is a major change in any of the following: i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Clearly delineated current organisation chart with line of functions and reporting relationships the Person In Charge (PIC), Head of Medical Services, relevant medical subspecialties services/units, consultants, medical practitioners and staff of the Medical Services.				
		2. Organisation chart of the service is endorsed, dated and accessible.				
		3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).				
	Facility Comments:					
9A.1.1.3	The Governing Body shall ensure that the Medical Services are organised in such a way as to:					
	a) facilitate the provision of medical services to patients in the Facility in a safe, efficient, effective, and caring manner and with due regard for the needs, dignity and privacy of patients and confidentiality of their personal information;					
	b) assure continuity of care;					
	c) address the professional needs of the medical practitioners;					
	d) ensure that the medical practitioners are involved in the formulation of policies and procedures concerning patient care appropriate to the scope of services of the Facility.					
	EVIDENCE OF COMPLIANCE	1. Department/Service operational policies that address (a) to (d).				
		2. Medical Staff By-Laws				
		3. Evidence of involvement of medical practitioners in the formulation of policies and procedures concerning patient care.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		4. Involvement of Head of the Service in the Medical and Dental Advisory Committee/Medical Advisory Committee and ward meetings.				
		5. Minutes of meetings				
		6. Proper and adequate equipment according to current standards.				
	Facility Comments:					
9A.1.1.4	There is a mechanism to ensure effective interaction between the Medical Services and the Governing Body on all clinical aspects of healthcare and other relevant matters in the Facility. This mechanism is defined in the policies of the Governing Body and is accomplished through: a) the appointment of a medical practitioner as the Head of Medical Services delineating his/her authority, responsibilities and accountabilities in a written document according to the relevant Acts to manage and control the Medical Services; b) Medical and Dental Advisory Committee (MDAC) to advise the Governing Body on issues related to clinical governance, i.e. in planning, coordinating, implementation, control and to improve activities relating to Medical Services.					
	EVIDENCE OF COMPLIANCE	1. Letter of appointment/assignment and delineation of duties and responsibilities of the Head of the Service.				
		2. Letter of appointment and Terms of Reference as member of the Medical and Dental Advisory Committee/Medical Advisory Committee.				
		3. Minutes of meetings of MDAC/Management				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS				
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING			
9A.1.1.5 CORE	The Head of Medical Services has: a) representation of the Service in committees and subcommittees where relevant; b) representation of the Service in clinical staff liaison meetings; c) involvement and provide regular input to the Senior Management Team.							
	EVIDENCE OF COMPLIANCE	1. Letter of representation of the Head of Service in committees and subcommittees where relevant, e.g. Blood Transfusion Committee, Medical Records Committee, Hospital Infection and Antibiotic Control Committee, etc.						
		2. Minutes of meetings of committees						
		3. Minutes of meeting of Senior Management Team.						
	Facility Comments:							
9A.1.1.6	The assessment, planning, direction, evaluation and continuity of clinical care are the responsibility of medical practitioners managing individual patients, thus ensuring clinical independence.							
	EVIDENCE OF COMPLIANCE	1. Medical Staff By-Laws; clause indicate clinical care responsibility of medical practitioners.						
		2. Documented evidence of clinical notes in the patient's medical record; e.g. documentation on assessment, planning, direction, evaluation and continuity of clinical care, valid name stamp of medical practitioner. Appropriateness of follow-up in terms of time interval & number of different managing practitioners. Evidence of ownership of patients, in keeping with patient-centered care						
		3. Documented evidence in clinical notes that there is no fragmentation of care of a patient between disciplines but there is teamwork when required.						
		4. Documented evidence in clinical notes that the indications for procedures done are valid.						

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		5. Evidence in clinical notes that the general management is as per current practise.				
	Facility Comments:					
9A.1.1.7	The Head of Medical Services shall be involved for the following aspects of management of the services: a) the preparation of budget and ensuring that expenditure remains within the budget allocated; b) human resource management and development; c) development of policies and procedures and ensuring compliance to them; d) facility and equipment management; e) safety and performance improvement activities and risk management.					
	EVIDENCE OF COMPLIANCE	1. Evidence of (a) to (e) in the minutes of meetings of Medical Services indicate the involvement of Head of Service.				
		2. Endorsement of policies and procedures				
		3. Request for allocation of budget and staffing				
		4. Implementation of performance improvement activities (refer to Quality Improvement activities)				
	Facility Comments:					
9A.1.1.8	Regular staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Medical Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.					
	EVIDENCE OF COMPLIANCE	1. Minutes are accessible, disseminated and acknowledged by the staff.				
		2. Attendance list of members with adequate representatives of the service.				
		3. Frequency of meetings as scheduled.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).				
	Facility Comments:					
9A.1.1.9	Where there are medical practitioners in training, there is evidence that: a) their responsibilities for patient care are documented; b) their training needs are identified; c) appropriate supervision and training are given to the medical practitioners concerned.					
	EVIDENCE OF COMPLIANCE	1. Structured training programmes for medical practitioners are in place.				
		2. Training timetable, continuing medical education and attendances list				
		3. Assessment reports				
		4. Log books				
	Facility Comments:					
9A.1.1.10	Appropriate statistics and records shall be maintained in relation to the provision of Medical Services and used for managing the services and patient care purposes.					
	EVIDENCE OF COMPLIANCE	1. Records are available but not limited to the following:				
		a) workload/census for inpatients and outpatients;				
		b) annual report;				
		c) accident/incident reports;				
		d) staffing number and staff profile;				
		e) staff training records;				
		f) data on performance improvement activities, including performance indicators.				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	Facility Comments:			

SURVEY ITEM & SELF-ASSESSMENT				
TOPIC 9A.2:	<u>HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT</u>			
STANDARD 9A.2.1	<u>CREDENTIALING AND PRIVILEGING</u> <i>The Medical Services shall be directed by a qualified and competent medical practitioner, and staffed by suitably qualified and competent clinical staff to achieve the goals and objectives of the Medical Services.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9A.2.1.1 CORE	There is documented evidence of appropriate training and competency for the granting of clinical privileging. The criteria for determining privileges are specified and documented. There is a structured process to ensure the stated criteria are uniformly applied to all applicants. These include: a) the criteria are designed to assure that patients will receive safe and quality care; b) the criteria for individual procedures are documented in detail; e.g. competency records/log books, application from the individual practitioner, recommendations from peer/referee and minutes of meeting; c) competency for each performance is dated, verified and signed by the supervisors; d) the period of time for which the privileges are to be granted is specified; e) current registration with the local professional registration bodies, e.g. Malaysian Medical Council, National Specialist Register (NSR); f) peer recommendations are taken into account when privileges are being considered; g) the recommendations of the relevant department and/or major professional services for privileges to be granted are taken into consideration. h) outcome of privileged procedures must be documented			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures are established to govern the credentialing and privileging processes which include items (a) to (g).				
		2. Compliance with policy and criteria for credentialing and privileging				
		3. Annual Practising Certificate (APC), National Specialist Register (NSR) certificates and privileging certificates.				
		4. Recommendations from peer/referee				
		5. Availability of the list of procedures requiring credentialing and privileging.				
		6. Availability of list of procedures to include core procedures specific to the disciplines performed by medical officers; competency records/log books.				
		7. Availability of list of procedures and its outcomes performed by each practitioner. Should be linked to annual appraisal.				
	Facility Comments:					
9A.2.1.2 CORE	Documented evidence of privileges conferred by the Governing Body is available and accessible to relevant staff at point of care.					
	EVIDENCE OF COMPLIANCE	1. Formal letter of assignment or certificate of privileging with stipulated timeline are issued and reviewed accordingly.				
		2. Updated list of staff with privileges conferred is made accessible at point of care.				
	Facility Comments:					
9A.2.1.3	Clinical staff performs within the privileges conferred.					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Verification of procedures performed by individuals at point of care within the awarded privileging rights with evidence of: a) List of procedures privileged. b) Clinical notes. The indication for the procedure clearly written			
	Facility Comments:				
9A.2.1.4	There are written and dated specific job descriptions for all categories of staff that include: a) qualification, training, experience and certification required for the position; b) lines of authority; c) accountability, functions, and responsibilities; d) reviewed when required and when there is a major change in any of the following: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations. e) administrative and clinical functions.				
	EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e). 2. Job description includes specialisation skills 3. Relevant privileges granted where applicable 4. The job description is acknowledged by the staff and signed by the Head of Service and dated.			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT							
STANDARD 9A.2.2	<u>STAFF TRAINING, EDUCATION, APPRAISAL AND RESEARCH</u> <i>The Facility and all staff shall demonstrate an ongoing commitment to continuing medical education.</i>						
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9A.2.2.1	There are continuing education activities for staff including medical practitioners to pursue professional interests and to prepare for current and future changes in practice.						
	EVIDENCE OF COMPLIANCE	1. Training calendar includes in-house/external courses/workshop/conferences					
		2. Contents of training programme					
		3. Training records on continuing education activities are kept and maintained for each staff including training in life support.					
		4. Certificate of attendance/degree/post basic training					
	Facility Comments:						
9A.2.2.2	The educational needs of staff and the Facility, as evidenced by the results of medical-care evaluation such as incident reports, performance improvement studies and complaints, are taken into consideration when the content and structure of educational activities are planned.						
	EVIDENCE OF COMPLIANCE	1. Evidence of inclusion of results of audit activities, e.g. mortality and morbidity reviews, incident reporting, etc in educational activities.					
		2. Evidence of improvement made from corrective or preventive measures from incident reports.					
	Facility Comments:						

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
9A.2.2.3	In a Facility where undergraduate medical, nursing and allied health training programmes are conducted, the Facility shall ensure there are sufficient skilled trained staff to provide clinical supervision of students. The facility should also provide a suitable number of patients to trainee ratio. The number of trainees in each category of staff should be limited based on the patient load and case mix.					
	EVIDENCE OF COMPLIANCE				1. Sufficient skilled trained staff to provide clinical supervision as per terms of Memorandum of Understanding.	
	Facility Comments:					
9A.2.2.4	There is evidence of training needs assessment and staff development plan which provide the knowledge and skills required for staff to maintain competency in their current positions and future advancement.					
	EVIDENCE OF COMPLIANCE				1. Training needs assessment is carried out and gaps identified.	
	2. A staff development plan based on training needs assessment is available.					
	3. Training schedule/calendar is in place.					
	4. Training module					
	Facility Comments:					
9A.2.2.5	Staff including medical practitioners receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff including medical practitioners is completed upon probationary period and as an annual exercise.				
	Facility Comments:					
9A.2.2.6	Where appropriate the Facility shall endeavour to undertake clinical research using available resources.					
	EVIDENCE OF COMPLIANCE	1. Documented evidence of research activities e.g. protocol, policies, consent etc.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT				
STANDARD 9A.2.3	<u>STAFFING LEVEL AND STAFF COMPETENCY</u> <i>The Head and staff of the Medical Services including medical practitioners are individuals qualified by education, training and experience commensurate with the requirements of the various positions and relevant laws.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9A.2.3.1	Deployment of all service providers for Medical Services takes the following factors into consideration: a) the number of persons deployed is proportional to the number of patients being cared for as in the regulatory requirements and for the intensity of care provided; b) the categories of service providers based on qualifications and experience providing care reflect the complexity of clinical problems being managed; c) staffing needs shall take into consideration absences due to leave or illness; double shift duties by clinical staff shall be documented and monitored; d) adequate staffing levels of appropriate competency shall be maintained throughout the hours the services are in operation. Where services need to be provided on a 24-hour basis, staffing level reflects the intensity of activities during each shift; e) where it is not possible to have service providers on duty on site, e.g. after working hours, provision is made for relevant medical practitioner to be available on call.			
	EVIDENCE OF COMPLIANCE			
	1. Documentation and planning on deployment of staff that includes but not limited to (a) to (e) with evidence of:			
	a) deployment based on staff to patient ratio, bed occupancy rate and complexity of cases;			
	b) special skills/training of staff;			
	c) contingency plan during acute shortage;			
	d) duty roster. e) Evidence that staff and doctors are not made to work more than the limits set by different authorities.			
	Facility Comments:			

SURVEY ITEM & SELF-ASSESSMENT					
STANDARD 9A.2.4	STAFF ORIENTATION <i>A structured orientation programme introduces new staff to their services, operational policies and relevant aspects of the Facility to prepare them for their roles and responsibilities.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9A.2.4.1	There is a structured orientation programme for all newly appointed staff to the Medical Services including medical practitioners and for those new to specific areas that include the following: a) explanation of the goals, objectives, policies and procedures of the Facility and those of the Medical Services; b) lines of authority and areas of responsibility; c) explanation of particular duties and functions; d) explanation of the methods of assigning clinical care and the standards of clinical practice; e) handover communication; f) processes for resolving practice dilemmas; g) information about safety procedures; h) training in basic/advanced life support techniques; i) methods of obtaining appropriate resource materials; j) staff appraisal procedures for the Medical Services; k) education on Patient and Family Rights; l) education on MSQH Standards requirements.				
	EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme			
		2. There is Medical Services orientation programme with relevant topics not limited to topics covered from (a) to (l).			
		3. Attendance list			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT					
<u>TOPIC 9A.3:</u>	<u>POLICIES AND PROCEDURES</u>				
<u>STANDARD</u> <u>9A.3.1</u>	<u>DEVELOPMENT, DERIVATION AND DOCUMENTATION</u> <i>There are written and dated policies and procedures for all activities of the Medical Services. These policies and procedures reflect current standards of medical practice, relevant regulations, statutory requirements, and the purposes of the services. These policies and procedures, terms of reference, by-laws, rules or regulations, state how the clinical staff including medical practitioners regulate themselves and provide patient care.</i>				
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9A.3.1.1 CORE	There are written policies and procedures for the Medical Services which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated. There is a mechanism for and evidence of a periodic review at least once in every three years.				
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for the service.			
		2. Policies and procedures are consistent with regulatory requirements and current standard practices.			
		3. Evidence of periodic review of policies and procedures.			
		4. The policies and procedures are endorsed and dated.			
	Facility Comments:				
9A.3.1.2	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved. Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.				
		2. Minutes of meeting with evidence of cross reference with other departments				
		3. Documented cross departmental policies				
	Facility Comments:					
9A.3.1.3 CORE	The policies and procedures documentation shall address at least the following topics and any others as required by relevant standards and laws: a) description of the organisational structure of the Medical Services; b) clinical practice guidelines; c) clinical documentation includes pain (or relevant presenting symptom / clinical alarm system) as the 5 th vital sign where appropriate; d) handover communication; e) drug prescription, dispensing and administration; f) blood transfusion; g) continuing of care including regular review of patient, review of investigation results, discharge (planned or At Own Risk), referrals and escort as necessary; h) pain management; i) management of patients under police custody/prisoner; j) management of cases with an infectious disease including notification of notifiable diseases; k) the responsibilities of the staff including medical practitioners in relation to internal and external disasters are documented, and known to the staff (contingency plan); l) incident reports shall be compiled, investigated, discussed and recorded and action plans implemented; m) end of life care; n) management of a death.					
EVIDENCE OF COMPLIANCE	1. Documented policies and procedures that address but not limited to (a) to (n).					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	Facility Comments:				
9A.3.1.4	Current policies and procedures are communicated to all staff.				
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/ Minutes of meetings			
		2. Circulation list and acknowledgement			
	Facility Comments:				
9A.3.1.5 CORE	There is evidence of compliance with policies and procedures.				
	EVIDENCE OF COMPLIANCE	1. Compliance with policies and procedures through:			
		a) interview of staff on practices;			
		b) verify with observation on practices;			
		c) results of audit on practices;			
		d) practices in line with established policies and procedures.			
		e) review of patient grievances relating to policies & procedures.			
	Facility Comments:				
9A.3.1.6	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.				
	EVIDENCE OF COMPLIANCE	1. Copies of relevant policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
9A.3.1.7	The services shall operate on a 24-hour basis providing a level of care appropriate to the activities of the patients in the Facility.							
	EVIDENCE OF COMPLIANCE	1. Operational policy on 24-hour services						
		2. Staffing level reflects good mix of experienced staff and the intensity of activities during each shift.						
		3. On-call roster is dated and authorised.						
	Facility Comments:							

SURVEY ITEM & SELF-ASSESSMENT				
TOPIC 9A.4:	<u>FACILITIES AND EQUIPMENT</u>			
STANDARD 9A.4.1	<i>The Head of Medical Services shall ensure adequate facilities and equipment that are safe and appropriate are available for the staff to function effectively and to meet the goals and objectives of the Medical Services.</i>			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT
				SURVEYOR RATING
9A.4.1.1	There are adequate and appropriate facilities and equipment with proper utilisation of space to enable staff to carry out their professional, teaching and administrative functions.			
	EVIDENCE OF COMPLIANCE	1. Adequate and proper utilisation of space.		
		2. Appropriate type of equipment to match the complexity of services.		
		3. Adequate facilities and equipment at each patient care area for safe care. (e.g. defibrillators, emergency cart, hand washing facilities etc)		
		4. Easy access and clear exit routes		
		5. Absence of overcrowding		
		6. Availability of areas to isolate patients who may aerosolize pathogens		
	Facility Comments:			
9A.4.1.2	Existing facilities shall take cognisance of the safety of staff and patients.			
	EVIDENCE OF COMPLIANCE	1. Design and layout of the unit, e.g. wards, treatment rooms, dirty and clean utility rooms, access, lighting, signage, etc address the safety aspects of patients and staff.		
		2. Adequate equipment and supplies for Medical Services, e.g. emergency trolley, functioning patient call bell, etc.		
		3. Equipment should have scheduled planned preventive maintenance (PPM).		

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	Facility Comments:				
9A.4.1.3	Suitable and adequate forms of communication and intercommunication systems and equipment are provided to enable clinical staff to communicate among themselves and with the other members of the healthcare team.				
	EVIDENCE OF COMPLIANCE	1. Appropriate telecommunication modalities available for daily operation and during emergencies.			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT				
STANDARD 9A.4.2	FACILITIES AND EQUIPMENT FOR PATIENT CARE <i>Adequate facilities and equipment shall be available to provide safe and effective patient care.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9A.4.2.1	Facilities are suitably located to facilitate easy access and to provide an atmosphere of user, environmental and 'disabled' friendly.			
	EVIDENCE OF COMPLIANCE			
	1. Floor plan indicates accessibility and patient and user friendly.			
	2. Feedback from patient satisfaction survey			
	3. Incident reporting relating to facilities if any.			
	Facility Comments:			
9A.4.2.2	Equipment, both for emergency and non-emergency usage, shall be appropriate to the level of care.			
	EVIDENCE OF COMPLIANCE			
	1. Availability of emergency and non-emergency equipment appropriate to level of care, such as defibrillator, emergency trolley, suction machine, electrocardiogram (ECG) machine, infusion or syringe pump, vital sign monitor, etc.			
	2. Scheduled checking of items in emergency trolley.			
	Facility Comments:			
9A.4.2.3	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.			
	EVIDENCE OF COMPLIANCE			
	1. Testing, commissioning and calibration records (certificates or stickers).			
	2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as evidence of compliance to the relevant standards and Acts.			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	Facility Comments:				
9A.4.2.4 CORE	There is evidence that the facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.				
	EVIDENCE OF COMPLIANCE	1. Planned Preventive Maintenance records such as schedule, stickers, etc.			
		2. Planned Replacement Programme where applicable			
		3. Complaint records			
		4. Asset inventory			
	Facility Comments:				
9A.4.2.5	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.				
	EVIDENCE OF COMPLIANCE	1. User training records			
		2. Competency assessment record			
		3. Letter of authorisation			
		4. List of staff trained and authorised to operate specialised equipment			
	Facility Comments:				
9A.4.2.6	Equipment is upgraded (based on evidence) from time to time so as to keep pace with advancement in operative and diagnostic techniques and technology.				
	EVIDENCE OF COMPLIANCE	1. Equipment are being replaced and upgraded to meet current standard of care and advancement in technology in a planned and systematic manner.			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT								
STANDARD 9A.4.3	<u>FACILITIES FOR MEDICAL RELATED OUTPATIENT SERVICES</u> <i>Where specialist outpatient services are provided, there are adequate outpatient clinics to enable the provision of safe and effective patient care, and patient privacy and confidentiality are assured.</i>							
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS					
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING				
9A.4.3.1	The Specialist Outpatient Services shall have the following features: a) the organisation and management of the clinics are planned so as to ensure prompt attention to patients, minimal waiting time, and avoidance of unnecessary visits by the patients; b) record keeping shall be efficient; c) an appointment or queuing system is used to manage patient consultations; d) the clinic is easily accessible including for non-ambulant patients and is easily identified through adequate signage; e) the clinic is located close to other facilities, e.g. radiology, laboratories and pharmacy; f) adequate provision is made for patient comfort g) Defaultment call back system (esp for high risk cases) h) Avenue for patients to access service between appointments.							
	EVIDENCE OF COMPLIANCE 1. The Specialist Outpatient Services address (a) to (f) with evidence of but not limited to the following: <table><tr><td>a) list of services available and offered to patients;</td><td></td></tr><tr><td>b) flow chart on work process;</td><td></td></tr></table>	a) list of services available and offered to patients;		b) flow chart on work process;				
a) list of services available and offered to patients;								
b) flow chart on work process;								

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		c) safe keeping of medical records;				
		d) security of data in Health Information System;				
		e) clinic appointment system;				
		f) monitoring of waiting time;				
		g) adequate and appropriate signage;				
		h) floor plan indicates accessibility to supporting services and optimisation of space;				
		i) adequate patient personal use items, e.g. wheelchair, etc;				
		j) adequate waiting area, rest rooms, refreshments, reading material and parking space.				
	Facility Comments:					
9A.4.3.2	Adequate numbers of rooms are provided to ensure patient privacy and confidentiality for various patient care activities including: a) consultation (not more than one patient in a room at any time); b) conduct of minor procedures and nursing procedures; maintain a register of procedures performed; c) performance of various tests.					
EVIDENCE OF COMPLIANCE	1. Adequate facilities for consultation and patient care activities that address (a) to (c) with evidence of but not limited to the following:					
	a) privacy of patient is ensured;					
	b) procedure room appropriately equipped;					
	c) patient monitoring device is available where required;					
	d) list of procedures done.					
Facility Comments:						

SURVEY ITEM & SELF-ASSESSMENT					
TOPIC 9A.5:		<u>SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES</u>			
STANDARD <u>9A.5.1</u>		<i>The Head of Medical Services shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Medical Services. The Head of Medical Services shall ensure compliance to monitoring of specific performance indicators.</i>			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9A.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Medical Services. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.				
	EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to (f)			
		2. Records on performance improvement activities			
		3. Minutes of performance improvement meetings			
		4. Performance improvement studies			
		5. Mortality and morbidity audits with remedial actions			
		6. Records on innovation if available.			
	Facility Comments:				
9A.5.1.2	The Head of Medical Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement activities to appropriate individual/ personnel within the respective services.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes of meetings				
		2. Letter of assignment of responsibilities				
		3. Job description				
	Facility Comments:					
9A.5.1.3	The Head of Medical Services shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility. Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.					
	EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:				
		a) Training of staff				
		b) Policy on incident reporting				
		c) Methodology of incident reporting				
		d) Register/records of incidents				
		2. Completed incident reports				
		3. Root Cause Analysis				
		4. Corrective and preventive action plans				
		5. Remedial measure				
		6. Minutes of meetings				
		7. Acknowledgment by Head of Service and PIC/Hospital Director				
		8. Feedback given to staff regarding incident reporting.				
	Facility Comments:					
9A.5.1.4 CORE	The staff including medical practitioners provide an appropriate peer group structure for performing the safety and performance improvement activities to accomplish clinical care evaluation.					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	a) The medical practitioners undertake clinical reviews of all risk assessments, incident reports, audits and safety and performance improvement activities: i) as a single committee for all safety and performance improvement activities; ii) in multidisciplinary committees within the service; iii) in a variety of purpose-specific committees, such as mortality and morbidity, infection control, blood transfusion, etc. b) Whatever structure is utilised, provision is made for review and analysis of the clinical work of each individual clinical service, department, unit or function.					
	EVIDENCE OF COMPLIANCE				1. Performance improvement activities	
					2. Minutes of meetings	
					3. Relevant reports and documents, e.g. clinical audit reports, incident reports, mortality and morbidity review reports, etc.	
	Facility Comments:					
9A.5.1.5 CORE	There is tracking and trending of specific performance indicators not limited to but at least two (2) of the following: a) number of mortality/morbidity audits/meetings being conducted in the department with documentation of cases discussed b) percentage of unplanned re-admission for the same complain within 72 hours of discharge c) Dengue Case Fatality Rate (Target: 0%) d) Percentage of patients who had blood culture done prior to starting treatment with the carbapenem group of antibiotics. (cross ref to Infection control - number 5) e) number of deaths occurring within 24 hrs of admission					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS									
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING								
	f) Percentage of Identification of causative pathogen for community acquired pneumonia. g) Number of healthcare worker infected with tuberculosis (or any other infectious diseases), the source of which is likely hospital-related. <u>Subspecialties units in the Medical Services</u> Subspecialties units in the Medical Services, e.g. Respiratory Medicine, Gastroenterology, Nephrology, Rheumatology, etc shall monitor any other two (2) indicators to support its goals and objectives. <table><tr><td rowspan="4">EVIDENCE OF COMPLIANCE</td><td>1. Specific performance indicators monitored.</td><td></td></tr><tr><td>2. Records on tracking and trending analysis.</td><td></td></tr><tr><td>3. Minutes of mortality/morbidity audits meetings</td><td></td></tr><tr><td>4. Remedial measures taken where appropriate</td><td></td></tr></table> Facility Comments:	EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored.		2. Records on tracking and trending analysis.		3. Minutes of mortality/morbidity audits meetings		4. Remedial measures taken where appropriate			
EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored.											
	2. Records on tracking and trending analysis.											
	3. Minutes of mortality/morbidity audits meetings											
	4. Remedial measures taken where appropriate											
9A.5.1.6	Feedback on results of safety and performance improvement activities are regularly communicated to the staff. <table><tr><td rowspan="3">EVIDENCE OF COMPLIANCE</td><td>1. Results on safety and performance improvement activities are accessible to staff.</td><td></td></tr><tr><td>2. Evidence of feedback via communication on results of performance improvement activities through continuing medical education/meetings.</td><td></td></tr><tr><td>3. Minutes of service/unit/committee meetings</td><td></td></tr></table> Facility Comments:	EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff.		2. Evidence of feedback via communication on results of performance improvement activities through continuing medical education/meetings.		3. Minutes of service/unit/committee meetings					
EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff.											
	2. Evidence of feedback via communication on results of performance improvement activities through continuing medical education/meetings.											
	3. Minutes of service/unit/committee meetings											
9A.5.1.7	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.											

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Documentation on performance improvement activities and performance indicators.				
		2. Policy statement on anonymity on patients and providers involved in performance improvement activities.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT				
SERVICE STANDARD 9B : CLINICAL SERVICES - SURGICAL RELATED SERVICES				
	<u>PREAMBLE</u> <i>Surgical Services play an integral role in delivering appropriate care and reducing unwarranted adverse events, as they meet the care people expect to be offered or receive, regardless of where they are treated in the Facility.</i> <i>The Surgical Services shall be organised, directed and coordinated with other services in the Facility to provide a high standard of inpatient and outpatient care to the community and cover the following:</i> <i>a) appropriateness of clinical care;</i> <i>b) unwarranted variation in care that is not explained by the clinical circumstances or personal choices of the medical practitioners in:-</i> <i>i) overuse of treatments or procedures that do not help patients get better;</i> <i>ii) underuse of care;</i> <i>iii) misuse (or errors) of doing something incorrectly and harming patients.</i> <i>In addition to the above, the Surgical Services also conduct teaching and training, research and audit activities where applicable.</i>			
<u>TOPIC 9B.1:</u> <u>STANDARD 9B.1.1</u>	<u>ORGANISATION AND MANAGEMENT</u> <i>The Surgical Services shall be organised, directed and coordinated with other services in the Facility to provide a high standard of inpatient and outpatient care to the community in a safe, efficient, effective, evidence based and caring manner and with due regard for the needs, dignity and privacy of patients and confidentiality of their personal information. The Surgical Services shall be easily accessible and continuity of care assured.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9B.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Surgical Services are clearly documented and measurable that indicates safety, quality and patient centred care. These reflect the roles and aspirations of the service and the needs of the community. These statements			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	are monitored, reviewed and revised as required accordingly and communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.				
		2. Goals and objectives of the Surgical Services in line with the Facility statements are available, endorsed and dated.				
		3. Evidence of planned reviews of the above statements.				
		4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)				
		5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.				
	Facility Comments:					
9B.1.1.2 CORE	There is an organisation chart which: a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head of Surgical Services, consultants, medical practitioners and staff of the Surgical Services; b) reflect the relevant surgical subspecialties services/units; c) is accessible to all staff and clients; d) is revised when there is a major change in any of the following: i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns.					
EVIDENCE OF COMPLIANCE	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head of Surgical Services, relevant surgical subspecialties services/units, consultants, medical practitioners and staff of the Surgical Services.					
	2. Organisation chart of the service is endorsed, dated and accessible.					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).				
	Facility Comments:				
9B.1.1.3	The Governing Body shall ensure that Surgical Services are organised in such a way as to: a) facilitate the provision of surgical services to patients in the Facility in a safe, efficient, effective, and caring manner and with due regard for the needs, dignity and privacy of patients and confidentiality of their personal information; b) assure continuity of care; c) address the professional needs of the medical practitioners; d) ensure that the medical practitioners are involved in the formulation of policies and procedures concerning patient care appropriate to the scope of services of the Facility.				
	EVIDENCE OF COMPLIANCE 1. Departmental/Service operational policies that address (a) to (d). 2. Medical Staff By-Laws 3. Evidence of involvement of medical practitioners in the formulation of policies and procedures concerning patient care. 4. Involvement of Head of the Service in the Medical and Dental Advisory Committee/Medical Advisory Committee and ward meetings. 5. Minutes of meetings 6. Proper and adequate equipment according to current standards.				
	Facility Comments:				
9B.1.1.4	There is a mechanism to ensure effective interaction between the Surgical Services and the Governing Body on all clinical aspects of healthcare and other relevant matters in the Facility. This mechanism is defined in the policies of the Governing Body and is accomplished through:				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS				
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING			
	a) the appointment of a medical practitioner as the Head of Surgical Services delineating his/her authority, responsibilities and accountabilities in a written document according to the relevant Acts to manage and control the Surgical Services; b) Medical and Dental Advisory Committee (MDAC) to advise the Governing Body on issues related to clinical governance, i.e. in planning, coordinating, implementation, control and to improve activities relating to Surgical Services.							
	EVIDENCE OF COMPLIANCE	1. Letter of appointment/assignment and delineation of duties and responsibilities of the Head of the Service.						
		2. Letter of appointment and Terms of Reference as member of the Medical and Dental Advisory Committee/Medical Advisory Committee.						
		3. Minutes of meetings of MDAC/Management						
	Facility Comments:							
9B.1.1.5 CORE	The Head of Surgical Services has: a) representation of the Service in committees and subcommittees where relevant; b) representation of the Service in clinical staff liaison meetings; c) involvement and provide regular input to the Senior Management Team.							
	EVIDENCE OF COMPLIANCE	1. Letter of representation of the Head of Service in committees and subcommittees where relevant, e.g.Blood Transfusion Committee, Medical Records Committee, Hospital Infection and Antibiotic Control Committee, etc.						
		2. Minutes of meetings of committees						
		3. Minutes of meeting of Senior Management Team.						
	Facility Comments:							

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9B.1.1.6	The assessment, planning, direction, evaluation and continuity of clinical care are the responsibility of medical practitioners managing individual patients, thus ensuring clinical independence.					
	EVIDENCE OF COMPLIANCE	1. Medical Staff By-Laws; clause indicate clinical care responsibility of medical practitioners.				
		2. Documented evidence of clinical notes in the patient's medical record; e.g. documentation on assessment, planning, direction, evaluation and continuity of clinical care, valid name stamp of medical practitioner.				
	Facility Comments:					
9B.1.1.7	The Head of Surgical Services shall be involved for the following aspects of management of the services: a) the preparation of budget and ensuring that expenditure remains within the budget allocated; b) human resource management and development; c) development of policies and procedures and ensuring compliance to them; d) facility and equipment management; e) safety and performance improvement activities and risk management.					
	EVIDENCE OF COMPLIANCE	1. Evidence of (a) to (e) in the minutes of meetings of Surgical Services indicate the involvement of Head of Service.				
		2. Endorsement of policies and procedures				
		3. Request for allocation of budget and staffing				
		4. Implementation of performance improvement activities				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9B.1.1.8	Regular staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Surgical Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.				
	EVIDENCE OF COMPLIANCE	1. Minutes are accessible, disseminated and acknowledged by the staff.			
		2. Attendance list of members with adequate representatives of the service.			
		3. Frequency of meetings as scheduled. (recommended a minimum of 4 meetings in a year)			
		4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).			
	Facility Comments:				
9B.1.1.9	Where there are medical practitioners in training, there is evidence that: a) their responsibilities for patient care are documented; b) their training needs are identified; c) appropriate supervision and training are given to the medical practitioners concerned.				
	EVIDENCE OF COMPLIANCE	1. Structured training programmes for medical practitioners are in place.			
		2. Training timetable, continuing medical education and attendances list			
		3. Assessment reports			
		4. Log books			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9B.1.1.10	Appropriate statistics and records shall be maintained in relation to the provision of Surgical Services and used for managing the services and patient care purposes.					
	EVIDENCE OF COMPLIANCE	1. Records are available but not limited to the following:				
		a) workload/census for inpatients and outpatients;				
		b) annual report;				
		c) accident/incident reports;				
		d) staffing number and staff profile;				
		e) staff training records;				
		f) data on performance improvement activities, including performance indicators.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT				
TOPIC 9B.2:	<u>HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT</u>			
STANDARD 9B.2.1	<u>CREDENTIALING AND PRIVILEGING</u> <i>The Surgical Services shall be directed by a qualified and competent medical practitioner, and staffed by suitably qualified and competent clinical staff to achieve the goals and objectives of the Surgical Services.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9B.2.1.1 CORE	There is documented evidence of appropriate training and competency for the granting of clinical privileging. The criteria for determining privileges are specified and documented. There is a structured process to ensure the stated criteria are uniformly applied to all applicants. These include: a) the criteria are designed to assure that patients will receive safe and quality care; b) the criteria for individual procedures are documented in detail; e.g. competency records/log books, application from the individual practitioner, recommendations from peer/referee and minutes of meeting; c) competency for each performance is dated, verified and signed by the supervisors; d) the period of time for which the privileges are to be granted is specified; e) current registration with the local professional registration bodies, e.g. Malaysian Medical Council, National Specialist Register (NSR); f) peer recommendations are taken into account when privileges are being considered; g) the recommendations of the relevant department and/or major professional services for privileges to be granted are taken into consideration.			
	EVIDENCE OF COMPLIANCE			
	1. Documented policies and procedures are established to govern the credentialing and privileging processes which include items (a) to (g).			
	2. Compliance with policy and criteria for credentialing and privileging			
	3. Annual Practising Certificate (APC), National Specialist Register (NSR) certificate and privileging certificate.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		4. Recommendations from peer/referee				
		5. Availability of the list of procedures requiring credentialing and privileging.				
		6. Availability of list of procedures to include core procedures specific to the disciplines performed by medical officers; competency records/log books. Credentialing and privileging must be given more weightage – either comply or non compliance				
	Facility Comments:					
9B.2.1.2 CORE	Documented evidence of privileges conferred by the Governing Body is available and accessible to relevant staff at point of care.					
	EVIDENCE OF COMPLIANCE	1. Formal letter of assignment or certificate of privileging with stipulated timeline are issued and reviewed accordingly.				
		2. Updated list of staff with privileges conferred is made accessible at point of care.				
	Facility Comments:					
9B.2.1.3 CORE	Clinical staff performs within the privileges conferred.					
	EVIDENCE OF COMPLIANCE	1. Verification of procedures performed by individuals at point of care within the awarded privileging rights with evidence of:				
		a) list of procedures privileged; accessibility of the list be made available at point of care				
		b) operating list;				
		c) operating notes/clinical notes.				
	Facility Comments:					
9B.2.1.4	There are written and dated specific job descriptions for all categories of staff that include:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	a) qualification, training, experience and certification required for the position; b) lines of authority; c) accountability, functions, and responsibilities; d) reviewed when required and when there is a major change in any of the following: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations. e) administrative and clinical functions.					
	EVIDENCE OF COMPLIANCE				1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e).	
					2. Job description includes specialisation skills	
					3. Relevant privileges granted where applicable	
					4. The job description is acknowledged by the staff and signed by the Head of Service and dated.	
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT							
STANDARD 9B.2.2	<i>STAFF TRAINING, EDUCATION, APPRAISAL AND RESEARCH</i> <i>The Facility and all staff shall demonstrate an ongoing commitment to continuing medical education.</i>						
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS			
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
9B.2.2.1	There are continuing education activities for staff including medical practitioners to pursue professional interests and to prepare for current and future changes in practice.						
	EVIDENCE OF COMPLIANCE	1. Training calendar includes in-house/external courses/workshop/conferences					
		2. Contents of training programme					
		3. Training records on continuing education activities are kept and maintained for each staff including training in life support.					
		4. Certificate of attendance/degree/post basic training					
	Facility Comments:						
9B.2.2.2	The educational needs of staff and the Facility, as evidenced by the results of medical-care evaluation such as incident reports, performance improvement studies and complaints, are taken into consideration when the content and structure of educational activities are planned.						
	EVIDENCE OF COMPLIANCE	1. Evidence of inclusion of results of audit activities, e.g. mortality and morbidity reviews, incident reporting, etc in educational activities.					
		2. Evidence of improvement made from corrective or preventive measures from incident reports.					
	Facility Comments:						
9B.2.2.3	In a Facility where undergraduate medical, nursing and allied health training programmes are conducted, the Facility shall ensure that there are sufficient skilled trained staff to provide clinical supervision of students.						

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Sufficient skilled trained staff to provide clinical supervision as per terms of Memorandum of Understanding.				
	Facility Comments:					
9B.2.2.4	There is evidence of training needs assessment and staff development plan which provides the knowledge and skills required for staff to maintain competency in their current positions and future advancement.					
	EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and gaps identified.				
		2. A staff development plan based on training needs assessment is available.				
		3. Training schedule/calendar is in place.				
		4. Training module				
	Facility Comments:					
9B.2.2.5	Staff including medical practitioners receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.					
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff including medical practitioner is completed upon probationary period and as an annual exercise.				
	Facility Comments:					
9B.2.2.6	Where appropriate the Facility shall endeavour to undertake clinical research using available resources.					
	EVIDENCE OF COMPLIANCE	1. Documented evidence of research activities, e.g. protocol, policies, consent, etc.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
STANDARD 9B.2.3		<u>STAFFING LEVEL AND STAFF COMPETENCY</u> <i>The Head and staff of the Surgical Services including medical practitioners are individuals qualified by education, training and experience commensurate with the requirements of the various positions and relevant laws.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9B.2.3.1	Deployment of all service providers for Surgical Services takes the following factors into consideration: a) the number of persons deployed is proportional to the number of patients being cared for as in the regulatory requirements and for the intensity of care provided; b) the categories of service providers based on qualifications and experience providing care reflect the complexity of clinical problems being managed; c) staffing needs shall take into consideration absences due to leave or illness; double shift duties by clinical staff shall be documented and monitored; d) adequate staffing levels of appropriate competency shall be maintained throughout the hours the services are in operation. Where services need to be provided on a 24-hour basis, staffing level reflects the intensity of activities during each shift; e) where it is not possible to have service providers on duty on site, e.g. after working hours, provision is made for relevant medical practitioner to be available on call.					
	EVIDENCE OF COMPLIANCE	1. Documentation and planning on deployment of staff that includes but not limited to (a) to (e) with evidence of:				
		a) deployment based on staff to patient ratio, bed occupancy rate and complexity of cases;				
		b) special skills/training of staff;				
		c) contingency plan during acute shortage;				
		d) duty roster.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT

STANDARD 9B.2.4	STAFF ORIENTATION <i>A structured orientation programme introduces new staff to their services, operational policies and relevant aspects of the Facility to prepare them for their roles and responsibilities.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9B.2.4.1	There is a structured orientation programme for all newly appointed staff to the Surgical Services including medical practitioners and for those new to specific areas that include the following: a) explanation of the goals, objectives, policies and procedures of the Facility and those of the Surgical Services; b) lines of authority and areas of responsibility; c) explanation of particular duties and functions; d) explanation of the methods of assigning clinical care and the standards of clinical practice; e) handover communication; f) processes for resolving practice dilemmas; g) information about safety procedures; h) training in basic/advanced life support techniques; i) methods of obtaining appropriate resource materials; j) staff appraisal procedures for the Surgical Services; k) education on Patient Centred Care; l) education on MSQH Standards requirements. m) information about care and treatment to limit barriers such as accessibility, languages, spiritual and cultural beliefs etc at least 2 languages; n) educate on management of clinical alarm system cross reference to nursing policy;			
	EVIDENCE OF COMPLIANCE 1. Policy requiring all new staff to attend a structured orientation programme			
	2. There is Surgical Services orientation programme with relevant topics not limited to topics covered from (a) to (l).			
	3. Attendance list			
	Facility Comments:			

SURVEY ITEM & SELF-ASSESSMENT						
<u>TOPIC 9B.3:</u>	<u>POLICIES AND PROCEDURES</u>					
<u>STANDARD</u> <u>9B.3.1</u>	<u>DEVELOPMENT, DERIVATION AND DOCUMENTATION</u> <i>There are written and dated policies and procedures for all activities of the Surgical Services. These policies and procedures reflect current standards of medical practice, relevant regulations, statutory requirements, and the purposes of the services. These policies and procedures, terms of reference, by-laws, rules or regulations, state how the clinical staff including medical practitioners regulate themselves and provide patient care.</i>					
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
9B.3.1.1 CORE	There are written policies and procedures for the Surgical Services which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated. There is a mechanism for and evidence of a periodic review at least once in every three years.					
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for the service.				
		2. Policies and procedures are consistent with regulatory requirements and current standard practices.				
		3. Evidence of periodic review of policies and procedures.				
		4. The policies and procedures are endorsed and dated.				
	Facility Comments:					
9B.3.1.2	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved. Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.					
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.				
		2. Minutes of meeting with evidence of cross reference with other departments				
		3. Documented cross departmental policies				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
9B.3.1.3 CORE	The policies and procedures documentation shall address at least the following topics and any others as required by relevant standards and laws: a) description of the organisational structure of the Surgical Services; b) clinical practice guidelines; c) clinical documentation includes pain as the 5th vital sign where appropriate; d) handover communication; e) drug prescription, dispensing and administration; f) blood transfusion; g) continuing of care including regular review of patient, review of investigation results, discharge (planned or At Own Risk), referrals and escort as necessary; h) pain management; i) management of patients under police custody/prisoner; j) management of cases with an infectious disease including notification of notifiable diseases; k) the responsibilities of the staff including medical practitioners in relation to internal and external disasters are documented, and known to the staff (contingency plan); n) incident reports shall be compiled, investigated, discussed and recorded and action plans implemented; l) end of life care; m) management of a death; n) safe use of lasers or other optic radiation devices cross reference to standard 3 o) sedation policy and procedures cross reference to anesthetist standard 10; p) management of high risk patients or high risk services – emergency, comatose, immunosuppressive, on life support, on dialysis, with communicable disease, in restraints, receiving chemotherapy, vulnerable patients and palliative care (nursing policy – standard 4) q) register of implantable medical devices registered under Medical Device Acts. r) Compliance to SOPs for the use of loan equipments					
	<table><tr><td>EVIDENCE OF COMPLIANCE</td><td>1. Documented policies and procedures that address but not limited to items (a) to (n).</td><td></td></tr></table>	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures that address but not limited to items (a) to (n).			
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures that address but not limited to items (a) to (n).				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9B.3.1.4	Current policies and procedures are communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings				
		2. Circulation list and acknowledgement				
	Facility Comments:					
9B.3.1.5 CORE	There is evidence of compliance with policies and procedures.					
	EVIDENCE OF COMPLIANCE	1. Compliance with policies and procedures through:				
		a) interview of staff on practices;				
		b) verify with observation on practices;				
		c) results of audit on practices;				
		d) practices in line with established policies and procedures.				
	Facility Comments:					
9B.3.1.6	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.					
	EVIDENCE OF COMPLIANCE	1. Copies of relevant policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.				
	Facility Comments:					
9B.3.1.7	The services shall operate on a 24-hour basis providing a level of care appropriate to the activities of the patients in the Facility.					
	EVIDENCE OF COMPLIANCE	1. Operational policy on 24-hour services				
		2. Staffing level reflects good mix of experienced staff and the intensity of activities during each shift.				
		3. On-call roster is dated and authorised.				
Facility Comments:						

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 9B.4:		<u>FACILITIES AND EQUIPMENT</u>				
<u>STANDARD 9B.4.1</u>		<i>The Head of Surgical Services shall ensure adequate facilities and equipment that are safe and appropriate are available for the staff to function effectively and to meet the goals and objectives of the Surgical Services.</i>				
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9B.4.1.1	There are adequate and appropriate facilities and equipment with proper utilisation of space to enable staff to carry out their professional, teaching and administrative functions.					
	EVIDENCE OF COMPLIANCE	1. Adequate and proper utilisation of space.				
		2. Appropriate type of equipment to match the complexity of services.				
		3. Adequate facilities and equipment at each patient care area for safe care. (e.g. defibrillators, emergency cart, hand washing facilities etc)				
		4. Easy access and clear exit routes				
		5. Absence of overcrowding				
	Facility Comments:					
9B.4.1.2	Existing facilities shall take cognisance of the safety of staff and patients.					
	EVIDENCE OF COMPLIANCE	1. Design and layout of the unit, e.g. wards, treatment rooms, dirty and clean utility rooms, access, lighting, signage, etc address the safety aspects of patients and staff.				
		2. Adequate equipment and supplies for Surgical Services, e.g. emergency trolley, functioning patient call bell, etc.				
		3. Equipment should have scheduled planned preventive maintenance (PPM).				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9B.4.1.3	Suitable and adequate forms of communication and intercommunication systems and equipment are provided to enable clinical staff to communicate among themselves and with the other members of the healthcare team.				
	EVIDENCE OF COMPLIANCE	1. Appropriate telecommunication modalities available for daily operation and during emergencies.			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT									
STANDARD 9B.4.2	FACILITIES AND EQUIPMENT FOR PATIENT CARE Adequate facilities and equipment shall be available to provide safe and effective patient care.								
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS				
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING			
9B.4.2.1	Facilities are suitably located to facilitate easy access and to provide an atmosphere of user, environmental and ‘disabled’ friendly.								
	EVIDENCE OF COMPLIANCE	1. Floor plan indicates accessibility and patient and user friendly.							
		2. Feedback from patient satisfaction survey							
		3. Incident reporting relating to facilities if any							
	Facility Comments:								
9B.4.2.2	Equipment, both for emergency and non-emergency usage, shall be appropriate to the level of care.								
	EVIDENCE OF COMPLIANCE	1. Availability of emergency and non-emergency equipment appropriate to level of care, such as defibrillator, emergency trolley, suction machine, electrocardiogram (ECG) machine, infusion or syringe pump, vital sign monitor, etc.							
		2. Scheduled checking of items in emergency trolley							
	Facility Comments:								
9B.4.2.3	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.								
	EVIDENCE OF COMPLIANCE	1. Testing, commissioning and calibration records (certificates or stickers)							
		2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as evidence of compliance to the relevant standards and Acts.							
	Facility Comments:								

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9B.4.2.4 CORE	There is evidence that the facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.				
	EVIDENCE OF COMPLIANCE	1. Planned Preventive Maintenance records such as schedule, stickers, etc.			
		2. Planned Replacement Programme where applicable			
		3. Complaint records			
		4. Asset inventory			
	Facility Comments:				
9B.4.2.5	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.				
	EVIDENCE OF COMPLIANCE	1. User training records			
		2. Competency assessment record			
		3. Letter of authorisation			
		4. List of staff trained and authorised to operate specialised equipment, example: - Syringe pump at the ICU vs wards - POP usage by orthopod - etc as appropriate			
	Facility Comments:				
9B.4.2.6	Equipment is upgraded (based on evidence) from time to time so as to keep pace with advancement in operative and diagnostic techniques and technology.				
	EVIDENCE OF COMPLIANCE	1. Equipment are being replaced and upgraded to meet current standard of care and advancement in technology in a planned and systematic manner.			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT						
STANDARD 9B.4.3	<i>FACILITIES FOR SURGICAL RELATED OUTPATIENT SERVICES</i> <i>Where specialist outpatient services are provided, there are adequate outpatient clinics to enable the provision of safe and effective patient care, and patient privacy and confidentiality are assured.</i>					
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9B.4.3.1	The Specialist Outpatient Services shall have the following features:					
	a) the organisation and management of the clinics are planned so as to ensure prompt attention to patients, minimal waiting time, and avoidance of unnecessary visits by the patients;					
	b) record keeping shall be efficient;					
	c) an appointment or queuing system is used to manage patient consultations;					
	d) the clinic is easily accessible including for non-ambulant patients and is easily identified through adequate signage;					
	e) the clinic is located close to other facilities, e.g. radiology, laboratories and pharmacy;					
	f) adequate provision is made for patient comfort.					
	EVIDENCE OF COMPLIANCE	1. The Specialist Outpatient Services address (a) to (f) with evidence of but not limited to the following:				
		a) list of services available and offered to patients;				
		b) flow chart on work process;				
		c) safe keeping of medical records;				
		d) security of data in Health Information System				
e) clinic appointment system;						
f) monitoring of waiting time;						
g) adequate and appropriate signage;						
h) floor plan indicates accessibility to supporting services and optimisation of space;						
i) adequate patient personal use items, e.g. wheelchair, etc;						

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		j) adequate waiting area, rest rooms, refreshments, reading material and parking space.				
	Facility Comments:					
9B.4.3.2	Adequate numbers of rooms are provided to ensure patient privacy and confidentiality for various patient care activities including:					
	a) consultation (not more than one patient in a room at any time);					
	b) conduct of minor procedures and nursing procedures; maintain a register of procedures performed;					
	c) performance of various tests.					
	d) specified room for laser and optic radiation procedures					
	EVIDENCE OF COMPLIANCE	1. Adequate facilities for consultation and patient care activities that address (a) to (c) with evidence of but not limited to the following:				
		a) privacy of patient is ensured;				
		b) procedure room appropriately equipped;				
		c) patient monitoring device is available where required;				
		d) list of procedures done.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 9B.5: SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES						
STANDARD 9B.5.1 <i>The Head of Surgical Services shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Surgical Services. The Head of Surgical Services shall ensure compliance to monitoring of specific performance indicators.</i>						
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9B.5.1.1 CORE	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Surgical Services. The process includes: a) Planned activities b) Data collection - POMR reporting be made mandatory so that data can be first collected before analysis be made c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.					
	EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to (f)				
		2. Records on performance improvement activities				
		3. Minutes of performance improvement meetings				
		4. Performance improvement studies				
		5. Mortality and morbidity audits with remedial actions				
		6. Records on innovation if available.				
	Facility Comments:					
9B.5.1.2	The Head of Surgical Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement activities to appropriate individual / personnel within the respective services.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes of meetings				
		2. Letter of assignment of responsibilities				
		3. Job description				
	Facility Comments:					
9B.5.1.3	The Head of Surgical Services shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility. Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.					
	EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:				
		a) Training of staff				
		b) Policy on incident reporting				
		c) Methodology of incident reporting				
		d) Register/records of incidents				
		2. Completed incident reports				
		3. Root Cause Analysis				
		4. Corrective and preventive action plans				
		5. Remedial measure				
		6. Minutes of meetings				
		7. Acknowledgment by Head of Service and PIC/Hospital Director				
		8. Feedback given to staff regarding incident reporting.				
	Facility Comments:					
9B.5.1.4 CORE	The staff including medical practitioners provide an appropriate peer group structure for performing the safety and performance improvement activities to accomplish clinical care evaluation.					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	a) The medical practitioners undertake clinical reviews of all risk assessments, incident reports, audits and safety and performance improvement activities: i) as a single committee for all safety and performance improvement activities; ii) in multidisciplinary committees within the service; iii) in a variety of purpose-specific committees, such as mortality and morbidity, infection control, blood transfusion, etc. b) Whatever structure is utilised, provision is made for review and analysis of the clinical work of each individual clinical service, department, unit or function.					
	EVIDENCE OF COMPLIANCE				1. Performance improvement activities	
	2. Minutes of meetings					
	3. Relevant reports and documents, e.g. clinical audit reports, incident reports, mortality and morbidity review reports, etc.					
	Facility Comments:					
9B.5.1.5 CORE	There is tracking and trending of specific performance indicators not limited to but at least two (2) of the following: a) number of mortality/morbidity audits/meetings being conducted in the department with documentation of cases discussed b) percentage of unplanned re-admission within 72 hours of discharge c) unplanned return to operating theatre within the same hospital admission following surgery d) percentage of patients with waiting time of more than seven (7) working days for fixation of long bone closed fracture <u>Subspecialties units in the Surgical Services</u> Subspecialties units in the Surgical Services, e.g. Neurosurgery, etc shall monitor any other two (2) indicators to support its goals and objectives. Breast and Endocrine surgery. - Recurrent laryngeal nerve injury in BENIGN thyroid surgery less than 3%. And percentage of clear margin in breast conservation surgery more than 75% Burn management – mortality of patient with severe burns be less than 30% Trauma – percentage of unplanned surgery returning to surgery less than 10% Cardiothoracic - to refer to the cardiothoracic surgeons	5				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS										
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING									
	Colorectal surgery – rate of colonic anastomotic leak of less than 5% whether colorectal surgeon or general surgeons offering the treatment General surgery – cancellation of elective surgery less than 10% monthly Hepatobiliary surgery – rate of common bile duct injury in laparoscopic cholecystectomy should be less than 0.5% (not in KKM KPI) Neurosurgery - time of intervention of less than 200 minutes for craniotomy from time of admission to OT table – in neurosurgical centers. Peads surgery – refer to peads surgeon Plastic surgery – to refer to plastic surgeon Upper GIT surgeon – mortality rate following oesophagectomy be less than 10% (no place for unprivileged surgeons) Urology – percentage of safe URS and lithotripsy be more than 95% (no bleeding/ gross haematuria after 48 hours, no septicaemia, no perforation and no unplanned ICU care. Vascular surgery – failed revascularisation surgery of less than 40% (fail = patients needing BKA or AKA within 14 days of revascularisation) every 3 months.-to prevent surgery on unviable limbs												
	<table><tr><td rowspan="4">EVIDENCE OF COMPLIANCE</td><td>1. Specific performance indicators monitored.</td><td></td></tr><tr><td>2. Records on tracking and trending analysis.</td><td></td></tr><tr><td>3. Minutes of mortality/morbidity audits meetings</td><td></td></tr><tr><td>4. Remedial measures taken where appropriate</td><td></td></tr></table>	EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored.		2. Records on tracking and trending analysis.		3. Minutes of mortality/morbidity audits meetings		4. Remedial measures taken where appropriate				
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	2. Records on tracking and trending analysis.												
	3. Minutes of mortality/morbidity audits meetings												
	4. Remedial measures taken where appropriate												
	Facility Comments:												
9B.5.1.6	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.												
	<table><tr><td rowspan="3">EVIDENCE OF COMPLIANCE</td><td>1. Results on safety and performance improvement activities are accessible to staff.</td><td></td></tr><tr><td>2. Evidence of feedback via communication on results of performance improvement activities through continuing medical education/meetings.</td><td></td></tr><tr><td>3. Minutes of service/unit/committee meetings</td><td></td></tr></table>	EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff.		2. Evidence of feedback via communication on results of performance improvement activities through continuing medical education/meetings.		3. Minutes of service/unit/committee meetings						
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	3. Minutes of service/unit/committee meetings												
	Facility Comments:												

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9B.5.1.7	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.					
	EVIDENCE OF COMPLIANCE	1. Documentation on performance improvement activities and performance indicators.				
		2. Policy statement on anonymity on patients and providers involved in performance improvement activities.				
	Facility Comments:					

SURVEYOR SUMMARY:

OVERALL RISK:

SURVEY ITEM & SELF-ASSESSMENT	
SERVICE STANDARD 9C : CLINICAL SERVICES - OBSTETRICS AND GYNAECOLOGY SERVICES	
	<u>PREAMBLE</u> <i>The Obstetrics and Gynaecology Services shall be organised, directed and coordinated with other services in the Facility to provide a high standard of inpatient and outpatient care to the community and address the following:</i> <i>a) appropriateness of clinical care;</i> <i>b) unwarranted variation in care that is not explained by the clinical circumstances or personal choices of the medical practitioners in:</i> <i>i) overuse of treatments or procedures that do not help patients get better;</i> <i>ii) underuse of care;</i> <i>iii) misuse (or errors) of doing something incorrectly and harming patients.</i> <i>In addition to the above, the Obstetrics and Gynaecology Services also conduct teaching and training, research and audit activities where applicable.</i>
<u>TOPIC 9C.1:</u> <u>STANDARD 9C.1.1</u>	<u>ORGANISATION AND MANAGEMENT</u> <i>The Obstetrics and Gynaecology Services shall be organised, directed and coordinated with other services in the Facility to provide a high standard of inpatient and outpatient care to the community in a safe, efficient, effective, evidence based and caring manner and with due regard for the needs, dignity and privacy of patients and confidentiality of their personal information. The Obstetrics and Gynaecology Services shall be easily accessible and continuity of care assured.</i>

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9C.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Obstetrics and Gynaecology Services are clearly documented and measurable that indicates safety, quality and patient centred care. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.				
	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.			
		2. Goals and objectives of the Obstetrics and Gynaecology Services in line with the Facility statements are available, endorsed and dated.			
		3. Evidence of planned reviews of the above statements.			
		4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)			
		5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.			
	Facility Comments:				
9C.1.1.2 CORE	There is an organisation chart which: a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head of Obstetrics and Gynaecology Services, consultants, medical practitioners and staff of the Obstetrics and Gynaecology Services; b) is accessible to all staff and clients; c) is revised when there is a major change in any of the following: i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head of Obstetrics and Gynaecology Services, consultants, medical practitioners and staff of the Obstetrics and Gynaecology Services.				
		2. Organisation chart of the service is endorsed, dated and accessible.				
		3. The organisation chart is revised when there is a major change in any of the items (c)(i) to (iv).				
	Facility Comments:					
9C.1.1.3	The Governing Body shall ensure that the Obstetrics and Gynaecology Services are organised in such a way as to: a) facilitate the provision of obstetrics and gynaecology services to patients in the Facility in a safe, efficient, effective and caring manner and with due regard for the needs, dignity and privacy of patients and confidentiality of their personal information; b) assure continuity of care; c) address the professional needs of the medical practitioners; d) ensure that the medical practitioners are involved in the formulation of policies and procedures concerning patient care appropriate to the scope of services of the Facility.					
EVIDENCE OF COMPLIANCE	1. Departmental/Service operational policies that address (a) to (d).					
	2. Medical Staff By-Laws					
	3. Evidence of involvement of medical practitioners in the formulation of policies and procedures concerning patient care.					
	4. Involvement of Head of the Service in the Medical and Dental Advisory Committee/Medical Advisory Committee and ward meetings.					
	5. Minutes of meetings					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	6. Proper and adequate equipment according to current standards.				
	Facility Comments:				
9C.1.1.4	There is a mechanism to ensure effective interaction between the Obstetrics and Gynaecology Services and the Governing Body on all clinical aspects of healthcare and other relevant matters in the Facility. This mechanism is defined in the policies of the Governing Body and is accomplished through: a) the appointment of a medical practitioner (appropriately qualified) as the Head of Obstetrics and Gynaecology Services delineating his/her authority, responsibilities and accountabilities in a written document according to the relevant Acts to manage and control the Obstetrics and Gynaecology Services; b) Medical and Dental Advisory Committee (MDAC) to advise the Governing Body on issues related to clinical governance, i.e. planning, coordinating, implementation, control and to improve activities relating to Obstetrics and Gynaecology Services. Note For facility without specialists, the Clinical Staff Committee functions as the Medical and Dental Advisory Committee.				
	EVIDENCE OF COMPLIANCE				
	1. Letter of appointment/assignment and delineation of duties and responsibilities of the Head of the Service.				
	2. Letter of appointment and Terms of Reference as member of the Medical and Dental Advisory Committee/Medical Advisory Committee.				
	3. Minutes of meetings of MDAC/Management				
	Facility Comments:				
9C.1.1.5 CORE	The Head of Obstetrics and Gynaecology Services has: a) representation of the Service in committees and subcommittees where relevant; b) representation of the Service in clinical staff liaison meetings. c) involvement and provide regular input to the Senior Management Team.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Letter of representation of the Head of Service in committees and subcommittees where relevant, e.g. Blood Transfusion Committee, Medical Records Committee, Hospital Infection and Antibiotic Control Committee, agencies, e.g. UNICEF (Baby Friendly Initiatives), etc.				
		2. Minutes of meetings of committees				
		3. Minutes of meeting of Senior Management Team.				
	Facility Comments:					
9C.1.1.6	The assessment, planning, direction, evaluation and continuity of clinical care are the responsibility of medical practitioners managing individual patients, thus ensuring clinical independence.					
	EVIDENCE OF COMPLIANCE	1. Medical Staff By-Laws; clause indicate clinical care responsibility of medical practitioners.				
		2. Documented evidence of clinical notes in the patient's medical record, e.g. documentation on assessment, planning, direction, evaluation and continuity of clinical care, valid name stamp of medical practitioner.				
	Facility Comments:					
9C.1.1.7	The Head of Obstetrics and Gynaecology Services shall be involved for the following aspects of management of the services:					
	a) the preparation of budget and ensuring that expenditure remains within the budget allocated;					
	b) human resource management and development;					
	c) development of policies and procedures and ensuring compliance to them;					
	d) facility and equipment management;					
	e) safety and performance improvement activities and risk management.					
	EVIDENCE OF COMPLIANCE	1. Evidence of (a) to (e) in the minutes of meetings of Obstetrics and Gynaecology Services indicate the involvement of Head of Service.				
		2. Endorsement of policies and procedures				
		3. Request for allocation of budget and staffing				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	4. Implementation of performance improvement activities				
	Facility Comments:				
9C.1.1.8	Regular staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Obstetrics and Gynaecology Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.				
	EVIDENCE OF COMPLIANCE				
	1. Minutes are accessible, disseminated and acknowledged by the staff.				
	2. Attendance list of members with adequate representatives of the service.				
	3. Frequency of meetings as scheduled.				
	4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).				
	Facility Comments:				
9C.1.1.9	Where there are medical practitioners in training, there is evidence that:				
	a) their responsibilities for patient care are documented;				
	b) their training needs are identified;				
	c) appropriate supervision and training are given to the medical practitioners concerned.				
	EVIDENCE OF COMPLIANCE				
	1. Structured training programmes for medical practitioners are in place.				
	2. Training timetable, continuing medical education and attendances list				
	3. Assessment reports				
	4. Log books				
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9C.1.1.10	Appropriate statistics and records shall be maintained in relation to the provision of Obstetrics and Gynaecology Services and used for managing the services and patient care purposes.					
	EVIDENCE OF COMPLIANCE	1. Records are available but not limited to the following:				
		a) workload/census for inpatients and outpatients;				
		b) annual report;				
		c) accident/incident reports;				
		d) staffing number and staff profile;				
		e) staff training records;				
		f) data on performance improvement activities including performance indicators.				
		g) Transfer of privileging rights within public facilities (can be accepted on transfer to the new facility within the validity of the C&P). However, the PIC of the healthcare facility shall conferee the current privileges.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT	
TOPIC 9C.2:	<u>HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT</u>
STANDARD <u>9C.2.1</u>	<u>CREDENTIALING AND PRIVILEGING</u> <i>The Obstetrics and Gynaecology Services shall be directed by a qualified and competent medical practitioner, and staffed by suitably qualified and competent clinical staff to achieve the goals and objectives of the Obstetrics and Gynaecology Services.</i>

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
9C.2.1.1 CORE	There is documented evidence of appropriate training and competency for the granting of clinical privileging. The criteria for determining privileges are specified and documented. There is a structured process to ensure the stated criteria are uniformly applied to all applicants. These include: a) the criteria are designed to assure that patients will receive safe and quality care; b) the criteria for individual procedures are documented in detail, e.g. competency records/log books, application from the individual practitioner, recommendations from peer/referee and minutes of meeting; c) competency for each performance is dated, verified and signed by the supervisors; d) the period of time for which the privileges are to be granted is specified; e) current registration with the local professional registration bodies, e.g. Malaysian Medical Council, National Specialist Register (NSR); f) peer recommendations are taken into account when privileges are being considered; g) the recommendations of the relevant department and/or major professional services for privileges to be granted are taken into consideration.					
	EVIDENCE OF COMPLIANCE				1. Documented policies and procedures are established to govern the credentialing and privileging processes which include items (a) to (g).	
					2. Compliance with policy and criteria for credentialing and privileging	

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		3. Annual Practising Certificate (APC), National Specialist Register (NSR) certificate and privileging certificate.				
		4. Recommendations from peer/referee				
		5. Availability of the list of procedures requiring credentialing and privileging.				
		6. Availability of list of procedures to include core procedures specific to the disciplines performed by medical officers; competency records/log books.				
	Facility Comments:					
9C.2.1.2 CORE	Documented evidence of privileges conferred by the Governing Body is available and accessible to relevant staff at point of care.					
	EVIDENCE OF COMPLIANCE	1. Formal letter of assignment or certificate of privileging with stipulated timeline are issued and reviewed accordingly.				
		2. Updated list of staff with privileges conferred is made accessible at point of care.				
	Facility Comments:					
9C.2.1.3	Clinical staff performs within the privileges conferred.					
	EVIDENCE OF COMPLIANCE	1. Verification of procedures performed by individuals at point of care within the awarded privileging rights with evidence of:				
		a) list of procedures privileged;				
		b) operating list;				
		c) operating notes/clinical notes.				
	Facility Comments:					
9C.2.1.4	There are written and dated specific job descriptions for all categories of staff that include:					
	a) qualifications, training, experience and certification required for the position;					
	b) lines of authority;					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	c) accountabilities, functions and responsibilities; d) reviewed when required and when there is a major change in any of the following: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations. e) administrative and clinical functions.					
	EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e).				
		2. Job description includes specialisation skills				
		3. Relevant privileges granted where applicable				
		4. The job description is acknowledged by the staff and signed by the Head of Service and dated.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT	
STANDARD 9C.2.2	<u>STAFF TRAINING, EDUCATION, APPRAISAL AND RESEARCH</u> <i>The Facility and all staff shall demonstrate an ongoing commitment to continuing medical education.</i>

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9C.2.2.1	There are continuing education activities for staff including medical practitioners to pursue professional interests and to prepare for current and future changes in practice.			
	EVIDENCE OF COMPLIANCE			
	1. Training calendar includes in-house/external courses/ workshop/conferences			
	2. Contents of training programme			
	3. Training records on continuing education activities are kept and maintained for each staff including training in life support.			
	4. Certificate of attendance/degree/post basic training			
	Facility Comments:			
9C.2.2.2	The educational needs of staff and the Facility, as evidenced by the results of medical-care evaluation such as incident reports, performance improvement studies and complaints, are taken into consideration when the content and structure of educational activities are planned.			
	EVIDENCE OF COMPLIANCE			
	1. Evidence of inclusion of results of audit activities, e.g. mortality and morbidity reviews, incident reporting, etc in educational activities.			
	2. Evidence of improvement made from corrective or preventive measures from incident reports.			
	Facility Comments:			
9C.2.2.3	In a Facility where undergraduate medical, nursing and allied health training programmes are conducted, the Facility shall ensure (together with their respective			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	teaching institution) that there are sufficient skilled trained staff to provide clinical supervision of students.				
	EVIDENCE OF COMPLIANCE	1. Sufficient skilled trained staff to provide clinical supervision as per terms of Memorandum of Understanding.			
	Facility Comments:				
9C.2.2.4	There is evidence of training needs assessment and staff development plan which provide the knowledge and skills required for staff to maintain competency in their current positions and future advancement.				
	EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and gaps identified.			
		2. A staff development plan based on training needs assessment is available.			
		3. Training schedule/calendar is in place.			
		4. Training module			
	Facility Comments:				
9C.2.2.5	Staff including medical practitioners receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.				
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff including medical practitioners is completed upon probationary period and as an annual exercise.			
	Facility Comments:				
9C.2.2.6	Where appropriate the Facility shall endeavour to undertake clinical research using available resources.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Documented evidence of research activities, e.g. protocol, policies, consent etc.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT	
STANDARD 9C.2.3	STAFFING LEVEL AND STAFF COMPETENCY <i>The Head and staff of the Obstetrics and Gynaecology Services including medical practitioners are individuals qualified by education, training and experience commensurate with the requirements of the various positions and relevant laws.</i>

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9C.2.3.1	Deployment of all service providers for Obstetrics and Gynaecology Services takes the following factors into consideration:			
	a) the number of persons deployed is proportional to the number of patients being cared for as in the regulatory requirements and for the intensity of care provided;			
	b) the categories of service providers based on qualifications and experience providing care reflect the complexity of clinical problems being managed;			
	c) staffing needs shall take into consideration absences due to leave or illness; double shift duties by clinical staff shall be documented and monitored;			
	d) adequate staffing levels of appropriate competency shall be maintained throughout the hours the services are in operation. Where services need to be provided on a 24-hour basis, staffing level reflects the intensity of activities during each shift;			
	e) where it is not possible to have service providers on duty on site, e.g. after working hours, provision is made for relevant medical practitioner to be available on call.			
	1. Documentation and planning on deployment of staff that includes but not limited to (a) to (e) with evidence of:			
EVIDENCE OF COMPLIANCE	a) deployment based on staff to patient ratio, bed occupancy rate and complexity of cases;			
	b) special skills/training of staff;			
	c) contingency plan during acute shortage;			
	d) duty roster.			
	e) Management (recovery) plan during disaster.			
Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT	
STANDARD 9C.2.4	STAFF ORIENTATION <i>A structured orientation programme introduces new staff to their services, operational policies and relevant aspects of the Facility to prepare them for their roles and responsibilities.</i>

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
9C.2.4.1	There is a structured orientation programme for all newly appointed staff to the Obstetrics and Gynaecology Services including medical practitioners and for those new to specific areas that include the following: a) explanation of the goals, objectives, policies and procedures of the Facility and those of the Obstetrics and Gynaecology Services; b) lines of authority and areas of responsibility; c) explanation of particular duties and functions; d) explanation of the methods of assigning clinical care and the standards of clinical practice; e) handover communication; f) processes for resolving practice dilemmas; g) information about safety procedures; h) training in basic/advanced life support techniques; i) methods of obtaining appropriate resource materials; j) staff appraisal procedures for the Obstetrics and Gynaecology Services; k) education on Patient and Family Rights; l) education on MSQH Standards requirements.					
	EVIDENCE OF COMPLIANCE				1. Policy requiring all new staff to attend a structured orientation programme.	
					2. There is Obstetrics and Gynaecology Services orientation programme with relevant topics not limited to topics covered from (a) to (l).	
					3. Attendance list	
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT	
TOPIC 9C.3:	<u>POLICIES AND PROCEDURES</u>
STANDARD 9C.3.1	<u>DEVELOPMENT, DERIVATION AND DOCUMENTATION</u> <i>There are written and dated policies and procedures for all activities of the Obstetrics and Gynaecology Services. These policies and procedures reflect current standards of medical practice, relevant regulations, statutory requirements, and the purposes of the services. These policies and procedures, terms of reference, by-laws, rules or regulations state how the clinical staff including medical practitioners regulate themselves and provide patient care.</i>

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9C.3.1.1 CORE	There are written policies and procedures for the Obstetrics and Gynaecology Services which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated.				
	There is a mechanism for and evidence of a periodic review at least once in every three years.				
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for the service.			
		2. Policies and procedures are consistent with regulatory requirements and current standard practices.			
		3. Evidence of periodic review of policies and procedures.			
		4. The policies and procedures are endorsed and dated.			
	Facility Comments:				
9C.3.1.2	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved.				
	Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.				
		2. Minutes of meeting with evidence of cross reference with other departments				
		3. Documented cross departmental policies				
	Facility Comments:					
9C.3.1.3 CORE	The policies and procedures documentation shall address at least the following topics and any others as required by relevant standards and laws: a) description of the organisational structure of the Obstetrics and Gynaecology Services; b) clinical practice guidelines; c) clinical documentation includes pain as the 5 th vital sign where appropriate; d) handover communication; e) drug prescription, dispensing and administration; f) blood transfusion; g) continuing of care including regular review of patient, review of investigation results, discharge (planned or At Own Risk), referrals and escort as necessary; h) pain management; i) management of patients under police custody/prisoner; j) management of cases with an infectious disease including notification of notifiable diseases; k) the responsibilities of the staff including medical practitioners in relation to internal and external disasters are documented, and known to the staff (contingency plan); l) incident reports shall be compiled, investigated, discussed and recorded and action plans implemented; m) end of life care; n) management of a death. o) Transfer (referral policy) - interfacility					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures that address but not limited to (a) to (n).				
	Facility Comments:					
9C.3.1.4	Current policies and procedures are communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings				
		2. Circulation list and acknowledgement				
	Facility Comments:					
9C.3.1.5 CORE	There is evidence of compliance with policies and procedures.					
	EVIDENCE OF COMPLIANCE	1. Compliance with policies and procedures through:				
		a) interview of staff on practices;				
		b) verify with observation on practices;				
		c) results of audit on practices;				
		d) practices in line with established policies and procedures.				
	Facility Comments:					
9C.3.1.6	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.					
	EVIDENCE OF COMPLIANCE	1. Copies of relevant policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS										
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING									
9C.3.1.7	The services shall operate on a 24-hour basis providing a level of care appropriate to the activities of the patients in the Facility. <table><tr><td rowspan="3">EVIDENCE OF COMPLIANCE</td><td>1. Operational policy on 24-hour services</td><td></td></tr><tr><td>2. Staffing level reflects good mix of experienced staff and the intensity of activities during each shift.</td><td></td></tr><tr><td>3. On-call roster is dated and authorised.</td><td></td></tr></table> Facility Comments:	EVIDENCE OF COMPLIANCE	1. Operational policy on 24-hour services		2. Staffing level reflects good mix of experienced staff and the intensity of activities during each shift.		3. On-call roster is dated and authorised.						
EVIDENCE OF COMPLIANCE	1. Operational policy on 24-hour services												
	2. Staffing level reflects good mix of experienced staff and the intensity of activities during each shift.												
	3. On-call roster is dated and authorised.												
9C.3.1.8 CORE	The Obstetrics and Gynaecology Services shall provide adequate level of monitoring appropriate to the obstetric patient's level of risk as follows: a) For non-high risk patients: i) maternal and fetal monitoring; frequency as prescribed; ii) monitoring in latent phase of labour shall be at appropriate level; iii) patients in established labour shall be managed in labour delivery suite; iv) the patient shall be reviewed by a specialist at least once daily. b) For high risk patients: i) the maternal and fetal monitoring shall be at an appropriate level as prescribed; ii) the patient shall be reviewed by a specialist at least twice a day. iii) Multidisciplinary (patient centered care) care where indicated. c) Very high risk patients shall be managed in the ICU/HDU (preferably obstetric ICU/HDU). <table><tr><td rowspan="4">EVIDENCE OF COMPLIANCE</td><td>1. Policies that address (a) to (c).</td><td></td></tr><tr><td>2. Documented evidence of compliance:</td><td></td></tr><tr><td>a) patient's medical record;</td><td></td></tr><tr><td>b) fetal monitoring records.</td><td></td></tr></table> Facility Comments:	EVIDENCE OF COMPLIANCE	1. Policies that address (a) to (c).		2. Documented evidence of compliance:		a) patient's medical record;		b) fetal monitoring records.				
EVIDENCE OF COMPLIANCE	1. Policies that address (a) to (c).												
	2. Documented evidence of compliance:												
	a) patient's medical record;												
	b) fetal monitoring records.												

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9C.3.1.9	The Obstetrics and Gynaecology Services shall ensure that antenatal, intrapartum and postnatal mothers have documented records to facilitate continuity of care. A copy of the record/card is given to the patient.					
	EVIDENCE OF COMPLIANCE	1. Policy on issuance of antenatal and postnatal records				
		2. Antenatal and postnatal patient records				
		3. Observation for compliance with policy				
	Facility Comments:					
9C.3.1.10	The Obstetrics and Gynaecology Services shall ensure that postnatal mothers being discharged will continue to receive postnatal care.					
	EVIDENCE OF COMPLIANCE	1. Policy on postnatal care that indicates mothers are appropriately referred to continue to receive postnatal home visits.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT	
TOPIC 9B.4:	<u>FACILITIES AND EQUIPMENT</u>
STANDARD <u>9C.4.1</u>	<i>The Head of Obstetrics and Gynaecology Services shall ensure adequate facilities and equipment that are safe and appropriate are available for the staff to function effectively and to meet the goals and objectives of the Obstetrics and Gynaecology Services.</i>

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9C.4.1.1	There are adequate and appropriate facilities and equipment with proper utilisation of space to enable staff to carry out their professional, teaching and administrative functions.					
	EVIDENCE OF COMPLIANCE	1. Adequate and proper utilisation of space				
		2. Appropriate type of equipment to match the complexity of services.				
		3. Adequate facilities and equipment at each patient care area for safe care (e.g. defibrillators, emergency cart, hand washing facilities, etc).				
		4. Easy access and clear exit routes				
		5. Absence of overcrowding				
	Facility Comments:					
9C.4.1.2	Existing facilities shall take cognisance of the safety of staff and patients.					
	EVIDENCE OF COMPLIANCE	1. Design and layout of the unit, e.g. wards, treatment rooms, dirty and clean utility rooms, access, lighting, signage, etc address the safety aspects of patients and staff.				
		2. Adequate equipment and supplies for Obstetrics and Gynaecology Services, e.g. emergency trolley, functioning patient call bell, etc.				
		3. Equipment should have scheduled planned preventive maintenance (PPM).				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	Facility Comments:				
9C.4.1.3	Suitable and adequate forms of communication and intercommunication systems and equipment are provided to enable clinical staff to communicate among themselves and with the other members of the healthcare team.				
	EVIDENCE OF COMPLIANCE	1. Appropriate telecommunication modalities available for daily operation and during emergencies.			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT	
STANDARD 9C.4.2	<i>FACILITIES AND EQUIPMENT FOR PATIENT CARE</i> <i>Adequate facilities and equipment shall be available to provide safe and effective patient care.</i>

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
9C.4.2.1	Facilities are suitably located to facilitate easy access and to provide an atmosphere of user, environmental and 'disabled' friendly.							
	EVIDENCE OF COMPLIANCE	1. Floor plan indicates accessibility and patient and user friendly.						
		2. Feedback from patient satisfaction survey						
		3. Incident reporting relating to facilities if any.						
	Facility Comments:							
9C.4.2.2	Equipment, both for emergency and non-emergency usage, shall be appropriate to the level of care.							
	EVIDENCE OF COMPLIANCE	1. Availability of emergency and non-emergency equipment appropriate to level of care, such as defibrillator, emergency trolley (adults and newborns), suction machine, electrocardiogram (ECG) machine, infusion or syringe pump, vital sign monitor, etc.						
		2. Scheduled checking of items in emergency trolley						
	Facility Comments:							
9C.4.2.3	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.							
		1. Testing, commissioning and calibration records (certificates or stickers)						

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as evidence of compliance to the relevant standards and Acts.			
	Facility Comments:				
9C.4.2.4 CORE	There is evidence that the facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.				
	EVIDENCE OF COMPLIANCE	1. Planned Preventive Maintenance records, such as schedule, stickers, etc.			
		2. Planned Replacement Programme where applicable			
		3. Complaint records			
		4. Asset inventory			
	Facility Comments:				
9C.4.2.5	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.				
	EVIDENCE OF COMPLIANCE	1. User training records			
		2. Competency assessment record			
		3. Letter of authorisation			
		4. List of staff trained and authorised to operate specialised equipment			
	Facility Comments:				
9C.4.2.6	Equipment is upgraded (based on evidence) from time to time so as to keep pace with advancement in operative and diagnostic techniques and technology.				
	EVIDENCE OF COMPLIANCE	1. Equipment are being replaced and upgraded to meet current standard of care and advancement in technology in a planned and systematic manner.			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT	
STANDARD 9C.4.3	<i>FACILITIES FOR OBSTETRICS & GYNAECOLOGY OUTPATIENT SERVICES</i> <i>Where specialist outpatient services are provided, there are adequate outpatient clinics to enable the provision of safe and effective patient care; and patient privacy and confidentiality are assured.</i>

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9C.4.3.1	The Specialist Outpatient Services shall have the following features:				
	a) the organisation and management of the clinics are planned so as to ensure prompt attention to patients, minimal waiting time, and avoidance of unnecessary visits by the patients;				
	b) record keeping shall be efficient;				
	c) an appointment or queuing system is used to manage patient consultations;				
	d) the clinic is easily accessible including for non-ambulant patients and is easily identified through adequate signage;				
	e) the clinic is located close to other facilities, e.g. radiology, laboratories and pharmacy;				
	f) adequate provision for patient comfort.				
	EVIDENCE OF COMPLIANCE	1. The Specialist Outpatient Services address (a) to (f) with evidence of but not limited to the following:			
		a) list of services available and offered to patients;			
		b) flow chart on work process;			
		c) safe keeping of medical records;			
		d) security of data in Health Information System;			
e) clinic appointment system;					
f) monitoring of waiting time;					
g) adequate and appropriate signage;					
h) floor plan indicates accessibility to supporting services and optimisation of space;					
i) adequate patient personal use items, e.g. wheelchair, etc;					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
		j) adequate waiting area, rest rooms, refreshments, reading material and parking space.					
		k) Baby friendly facilities.					
	Facility Comments:						
9C.4.3.2	Adequate numbers of rooms are provided to ensure patient privacy and confidentiality for various patient care activities including: a) consultation (not more than one patient in a room at any time, if possible); b) conduct of minor procedures and nursing procedures; maintain a register of procedures performed; c) performance of various tests.						
EVIDENCE OF COMPLIANCE	1. Adequate facilities for consultation and patient care activities that address (a) to (c) with evidence of but not limited to the following:						
	a)	privacy of patient is ensured;					
	b)	procedure room appropriately equipped;					
	c)	patient monitoring device is available where required;					
	d)	list of procedures done.					
Facility Comments:							

SURVEY ITEM & SELF-ASSESSMENT	
TOPIC 9C.5:	<u>SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES</u>
STANDARD 9C.5.1	<i>The Head of Obstetrics and Gynaecology Services shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Obstetrics and Gynaecology Services. The Head of Obstetrics and Gynaecology Services shall ensure compliance to monitoring of specific performance indicators.</i>

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9C.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Obstetrics and Gynaecology Services. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.				
	EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to (f)			
		2. Records on performance improvement activities			
		3. Minutes of performance improvement meetings			
		4. Performance improvement studies			
		5. Mortality and morbidity audits with remedial actions			
		6. Records on innovation if available.			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9C.5.1.2	The Head of Obstetrics and Gynaecology Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement activities to appropriate individual/personnel within the respective services.			
	EVIDENCE OF COMPLIANCE			
	1. Minutes of meetings			
	2. Letter of assignment of responsibilities			
	3. Job description			
	Facility Comments:			
9C.5.1.3	The Head of Obstetrics and Gynaecology Services shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility.			
	Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.			
	EVIDENCE OF COMPLIANCE			
	1. System for incident reporting is in place, which include:			
	a) Training of staff			
	b) Policy on incident reporting			
	c) Methodology of incident reporting			
	d) Register/records of incidents			
	2. Completed incident reports			
	3. Root Cause Analysis			
	4. Corrective and preventive action plans			
	5. Remedial measure			
	6. Minutes of meetings			
	7. Acknowledgment by Head of Service and PIC/Hospital Director			
	8. Feedback given to staff regarding incident reporting.			
	Facility Comments:			

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS							
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING						
9C.5.1.4 CORE	The Obstetrics and Gynecology Services has Clinical (Obstetrics) Risk Management Programme that provides an appropriate peer group structure for performing the safety and performance improvement activities to accomplish clinical care evaluation. a) The medical practitioners undertake clinical reviews of all risk assessments, incident reports, audits and safety and performance improvement activities: i) in multidisciplinary committees within the service; ii) in a variety of purpose-specific committees, such as mortality and morbidity, and infection control. b) Whatever structure is utilised, provision is made for review and analysis of the clinical work of each individual clinical service, unit or function. <table><tr><td rowspan="3">EVIDENCE OF COMPLIANCE</td><td>1. Risk Management Programme</td><td></td></tr><tr><td>2. Minutes of meetings</td><td></td></tr><tr><td>3. Relevant reports and documents, e.g. clinical audit reports, incident reports, mortality and morbidity review reports, etc.</td><td></td></tr></table> Facility Comments:	EVIDENCE OF COMPLIANCE	1. Risk Management Programme		2. Minutes of meetings		3. Relevant reports and documents, e.g. clinical audit reports, incident reports, mortality and morbidity review reports, etc.			
EVIDENCE OF COMPLIANCE	1. Risk Management Programme									
	2. Minutes of meetings									
	3. Relevant reports and documents, e.g. clinical audit reports, incident reports, mortality and morbidity review reports, etc.									
9C.5.1.5 CORE	There is tracking and trending of specific performance indicators not limited to but at least two (2) of the following: a) <u>Facility with specialists:</u> i) Emergency and Elective Caesarean Rates (Target: Elective caesarean rates less than 30%) ii) Undiagnosed ureteric injury for benign gynaecological surgery (Target: ≤1%) iii) Maternal Mortality Ratio (sentinel event) iv) Incidence of 3rd and 4th degree perineal tear following vaginal delivery (Target: ≤10%) b) <u>District Facility without specialists: Maternity Services</u> i) Emergency and Elective Caesarean Rates ii) Maternal Mortality Ratio (sentinel event) iii) Incidence of 3rd and 4th degree perineal tear following vaginal delivery (Target: less than 5%)									

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored.				
		2. Records on tracking and trending analysis.				
		3. Minutes of mortality/morbidity audits meetings				
		4. Remedial measures taken where appropriate				
	Facility Comments:					
9C.5.1.6	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.					
	EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff.				
		2. Evidence of feedback via communication on results of performance improvement activities through continuing medical education/meetings.				
		3. Minutes of service/unit/committee meetings				
	Facility Comments:					
9C.5.1.7	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.					
	EVIDENCE OF COMPLIANCE	1. Documentation on performance improvement activities and performance indicators.				
		2. Policy statement on anonymity on patients and providers involved in performance improvement activities.				
	Facility Comments:					

SERVICE SUMMARY	
SURVEYOR SUMMARY:	
OVERALL RATING:	
OVERALL RISK:	

SURVEY ITEM & SELF-ASSESSMENT			
SERVICE STANDARD 9D : CLINICAL SERVICES - PAEDIATRIC SERVICES			
	<u>PREAMBLE</u> <i>The Paediatric Services shall be organised, directed and coordinated with other services in the Facility to provide a high standard of inpatient and outpatient care to the community and cover the following:</i> <i>a) appropriateness of clinical care;</i> <i>b) unwarranted variation in care that is not explained by the clinical circumstances or personal choices of the medical practitioners in:</i> <i>i) overuse of treatments or procedures that do not help patients get better;</i> <i>ii) underuse of care;</i> <i>iii) misuse (or errors) of doing something incorrectly and harming patients.</i> <i>In addition to the above, the Paediatric Services also conduct teaching and training, research and audit activities where applicable.</i>		
<u>TOPIC 9D.1:</u> <u>STANDARD 9D.1.1</u>	<u>ORGANISATION AND MANAGEMENT</u> <i>The Paediatric Services shall be organised, directed and coordinated with other services in the Facility to provide a high standard of inpatient and outpatient care to the community in a safe, efficient, effective, evidence based and caring manner and with due regard for the needs, dignity and privacy of patients and confidentiality of their personal information. The Paediatric Services shall be easily accessible and continuity of care assured.</i>		
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT
			SURVEYOR RATING
9D.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Paediatric Services are clearly documented and measurable that indicates safety, quality and patient centred care. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.		

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.					
		2. Goals and objectives of the Paediatric Services in line with the Facility statements are available, endorsed and dated.					
		3. Evidence of planned reviews of the above statements.					
		4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)					
		5. Achievement of goals and objectives are monitored, reviewed and revised accordingly					
	Facility Comments:						
9D.1.1.2 CORE	There is an organisation chart which:						
	a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head of Paediatric Services, consultants, medical practitioners and staff of the Paediatric Services;						
	b) is accessible to all staff and clients;						
	c) is revised when there is a major change in any of the following:						
	i) organisation;						
	ii) functions;						
	iii) reporting relationships;						
EVIDENCE OF COMPLIANCE	iv) staffing patterns.						
	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head of Paediatric Services, consultants, medical practitioners and staff of the Paediatric Services.						
	2. Organisation chart of the service is endorsed, dated and accessible.						
	3. The organisation chart is revised when there is a major change in any of the items (c)(i) to (iv).						
Facility Comments:							
9D.1.1.3	The Governing Body shall ensure that the Paediatric Services are organised in such a way as to:						

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	a) facilitate the provision of paediatric services to patients in the Facility in a safe, efficient, effective, and caring manner and with due regard for the needs, dignity and privacy of patients and confidentiality of their personal information; b) assure continuity of care; c) address the professional needs of the medical practitioners; d) ensure that the medical practitioners are involved in the formulation of policies and procedures concerning patient care appropriate to the scope of services of the Facility.				
	EVIDENCE OF COMPLIANCE	1. Departmental/Service operational policies that address (a) to (d).			
		2. Medical Staff By-Laws			
		3. Evidence of involvement of medical practitioners in the formulation of policies and procedures concerning patient care.			
		4. Involvement of Head of the Service in the Medical and Dental Advisory Committee/Medical Advisory Committee and ward meetings.			
		5. Minutes of meetings			
		6. Proper and adequate equipment according to current standards.			
	Facility Comments:				
9D.1.1.4	There is a mechanism to ensure effective interaction between the Paediatric Services and the Governing Body on all clinical aspects of healthcare and other relevant matters in the Facility. This mechanism is defined in the policies of the Governing Body and is accomplished through: a) the appointment of a medical practitioner as the Head of Paediatric Services delineating his/her authority, responsibilities and accountabilities in a written document according to the relevant Acts to manage and control the Paediatric Services; b) Medical and Dental Advisory Committee (MDAC) to advise the Governing Body on issues related clinical governance, i.e. planning, coordinating, implementation, control and to improve activities relating to Paediatric Services.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Letter of appointment/assignment and delineation of duties and responsibilities of the Head of the Service.				
		2. Letter of appointment and Terms of Reference as member of the Medical and Dental Advisory Committee/Medical Advisory Committee.				
		3. Minutes of meetings of MDAC/Management				
	Facility Comments:					
9D.1.1.5 CORE	The Head of Paediatric Services has: a) representation of the Service in committees and subcommittees where relevant; b) representation of the Service in clinical staff liaison meetings. c) involvement and provide regular input to the Senior Management Team.					
	EVIDENCE OF COMPLIANCE	1. Letter of representation of the Head of Service in committees and subcommittees where relevant, e.g. Blood Transfusion Committee, Medical Records Committee, Hospital Infection and Antibiotic Control Committee, agencies e.g. UNICEF (Baby Friendly Initiatives), etc.				
		2. Minutes of meetings of committees				
		3. Minutes of meeting of Senior Management Team.				
	Facility Comments:					
9D.1.1.6	The assessment, planning, direction, evaluation and continuity of clinical care are the responsibility of medical practitioners managing individual patients, thus ensuring clinical independence.					
	EVIDENCE OF COMPLIANCE	1. Medical Staff By-Laws; clause indicate clinical care responsibility of medical practitioners.				
		2. Documented evidence of clinical notes in the patient's medical record; e.g. documentation on assessment, planning, direction, evaluation and continuity of clinical care, valid name stamp of medical practitioner (in hospitals without Hospital Information System).				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9D.1.1.7	The Head of Paediatric Services shall be involved for the following aspects of management of the services: a) the preparation of budget and ensuring that expenditure remains within the budget allocated; b) human resource management and development; c) development of policies and procedures and ensuring compliance to them; d) facility and equipment management; e) safety and performance improvement activities and risk management.				
	EVIDENCE OF COMPLIANCE	1. Evidence of (a) to (e) in the minutes of meetings of Paediatric Services indicate the involvement of Head of Service.			
		2. Endorsement of policies and procedures			
		3. Request for allocation of budget and staffing			
		4. Implementation of performance improvement activities eg. Critical Incidences Meeting			
	Facility Comments:				
9D.1.1.8	Regular staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Paediatric Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.				
	EVIDENCE OF COMPLIANCE	1. Minutes are accessible, disseminated and acknowledged by the staff.			
		2. Attendance list of members with adequate representatives of the service.			
		3. Frequency of meetings as scheduled.			
		4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9D.1.1.9	Where there are medical practitioners in training, there is evidence that: a) their responsibilities for patient care are documented; b) their training needs are identified; c) appropriate supervision and training are given to the medical practitioners concerned.				
	EVIDENCE OF COMPLIANCE	1. Structured training programmes for medical practitioners are in place.			
		2. Training timetable, continuing medical education and attendances list			
		3. Assessment reports and Log Books			
		4. Job responsibilities of the medical practitioners in training eg Senarai Tugas, Orientation Manual			
	Facility Comments:				
9D.1.1.10	Appropriate statistics and records shall be maintained in relation to the provision of Paediatric Services and used for managing the services and patient care purposes.				
	EVIDENCE OF COMPLIANCE	1. Records are available but not limited to the following:			
		a) workload/census for inpatients and outpatients;			
		b) annual report;			
		c) accident/incident reports;			
		d) staffing number and staff profile;			
		e) staff training records;			
		f) data on performance improvement activities, including performance indicators			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT					
<u>TOPIC 9B.2:</u>		<u>HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT</u>			
<u>STANDARD</u> <u>9D.2.1</u>		<u>CREDENTIALING AND PRIVILEGING</u> <i>The Paediatric Services shall be directed by a qualified and competent medical practitioner, and staffed by suitably qualified and competent clinical staff to achieve the goals and objectives of the Paediatric Services.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9D.2.1.1 CORE	There is documented evidence of appropriate training and competency for the granting of clinical privileging. The criteria for determining privileges are specified and documented. There is a structured process to ensure the stated criteria are uniformly applied to all applicants. These include: a) the criteria are designed to assure that patients will receive safe and quality care; b) the criteria for individual procedures are documented in detail, e.g. competency records/log books, application from the individual practitioner, recommendations from peer/referee and minutes of meeting; c) competency for each performance is dated, verified and signed by the supervisors; d) the period of time for which the privileges are to be granted is specified; e) current registration with the local professional registration bodies, e.g. Malaysian Medical Council, National Specialist Register (NSR); f) peer recommendations are taken into account when privileges are being considered; g) the recommendations of the relevant department and/or major professional services for privileges to be granted are taken into consideration.				
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures are established to govern the credentialing and privileging processes which include items (a) to (g).			
		2. Compliance with policy and criteria for credentialing and privileging			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		3. Annual Practising Certificate (APC), National Specialist Register (NSR) certificate and privileging certificate.				
		4. Recommendations from peer/referee				
		5. Availability of the list of procedures requiring credentialing and privileging.				
		6. Availability of list of procedures to include core procedures specific to the disciplines performed by medical officers; competency records/log books				
	Facility Comments:					
9D.2.1.2 CORE	Documented evidence of privileges conferred by the Governing Body is available and accessible to relevant staff at point of care.					
	EVIDENCE OF COMPLIANCE	1. Formal letter of assignment or certificate of privileging with stipulated timeline are issued and reviewed accordingly.				
		2. Updated list of staff with privileges conferred is made accessible at point of care.				
	Facility Comments:					
9D.2.1.3	Clinical staff performs within the privileges conferred.					
	EVIDENCE OF COMPLIANCE	1. Verification of procedures performed by individuals at point of care within the awarded privileging rights with evidence of:				
		a) list of procedures privileged;				
		b) operating list eg endoscopy and bronchoscopy lists.				
	Facility Comments:					
9C.2.1.4	There are written and dated specific job descriptions for all categories of staff that include:					
	a) qualification, training, experience and certification required for the position;					
	b) lines of authority;					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	c) accountability, functions, and responsibilities; d) reviewed when required and when there is a major change in any of the following: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations. e) administrative and clinical functions.					
	EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e).				
		2. Job description includes specialisation skills				
		3. Relevant privileges granted where applicable				
		4. The job description is acknowledged by the staff and signed by the Head of Service and dated.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
STANDARD 9D.2.2	<i>STAFF TRAINING, EDUCATION, APPRAISAL AND RESEARCH</i> <i>The Facility and all staff shall demonstrate an ongoing commitment to continuing medical education.</i>					
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9D.2.2.1	There are continuing education activities for staff including medical practitioners to pursue professional interests and to prepare for current and future changes in practice, as well as education in patient centered care.					
	EVIDENCE OF COMPLIANCE	1. Training calendar includes in-house/external courses/ workshop/conferences				
		2. Training on patient-centered care eg. a) Patient and Family Rights b) communication skills eg 10S, Budaya Korporat				
		3. Contents of training programme				
		4. Training records on continuing education activities are kept and maintained for each staff including training in life support.				
		5. Certificate of attendance/degree/post basic training				
	Facility Comments:					
9D.2.2.2	The educational needs of staff and the Facility, as evidenced by the results of medical-care evaluation such as incident reports, performance improvement studies and complaints, are taken into consideration when the content and structure of educational activities are planned.					
	EVIDENCE OF COMPLIANCE	1. Evidence of inclusion of results of audit activities, e.g. mortality and morbidity reviews, incident reporting, etc in educational activities.				
		2. Evidence of improvement made from corrective or preventive measures from incident reports.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9D.2.2.3	In a Facility where undergraduate medical, nursing and allied health training programmes are conducted, the Facility shall ensure that there are sufficient skilled trained staff to provide clinical supervision of students.					
	EVIDENCE OF COMPLIANCE	1. Sufficient skilled trained staff to provide clinical supervision as per terms of Memorandum of Understanding.				
		2. For Nursing training program, there will be 1 Clinical Instructor to 15 students				
	Facility Comments:					
9D.2.2.4	There is evidence of training needs assessment and staff development plan which provides the knowledge and skills required for staff to maintain competency in their current positions and future advancement.					
	EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and gaps identified eg list of core training modules/ lectures attended eg NRP, Infection Control & Asthma				
		2. A staff development plan based on training needs assessment is available.				
		3. Training schedule/calendar is in place.				
		4. Training module				
	Facility Comments:					
9D.2.2.5	Staff including medical practitioners receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.					
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff including medical practitioners is completed upon probationary period/ clinical posting or as an annual exercise eg Case Based Discussion (CBD) , Clinical Examination (CEX) and Sasaran Kerja Tahunan (SKT).				
		Facility Comments:				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9D.2.2.6	Where appropriate the Facility shall endeavour to undertake clinical research using available resources.					
	EVIDENCE OF COMPLIANCE	1. Documented evidence of research activities e.g. protocol, policies, consent etc.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT					
STANDARD 9D.2.3	<u>STAFFING LEVEL AND STAFF COMPETENCY</u> <i>The Head and staff of the Paediatric Services including medical practitioners are individuals qualified by education, training and experience commensurate with the requirements of the various positions and relevant laws.</i>				
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9D.2.3.1	Deployment of all service providers for Paediatric Services takes the following factors into consideration:				
	a) the number of persons deployed is proportional to the number of patients being cared for as in the regulatory requirements and for the intensity of care provided;				
	b) the categories of service providers based on qualifications and experience providing care reflect the complexity of clinical problems being managed;				
	c) staffing needs shall take into consideration absences due to leave or illness; double shift duties by clinical staff shall be documented and monitored;				
	d) adequate staffing levels of appropriate competency shall be maintained throughout the hours the services are in operation. Where services need to be provided on a 24-hour basis, staffing level reflects the intensity of activities during each shift;				
	e) where it is not possible to have service providers on duty on site, e.g. after working hours, provision is made for relevant medical practitioner to be available on call.				
	EVIDENCE OF COMPLIANCE				1. Documentation and planning on deployment of staff that includes but not limited to (a) to (e) with evidence of:
a) deployment based on staff to patient ratio, bed occupancy rate and complexity of cases;					
b) special skills/training of staff;					
c) contingency plan during acute shortage;					
d) duty roster.					
Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT											
STANDARD 9D.2.4	STAFF ORIENTATION <i>A structured orientation programme introduces new staff to their services, operational policies and relevant aspects of the Facility to prepare them for their roles and responsibilities.</i>										
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS								
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING							
9D.2.4.1	There is a structured orientation programme for all newly appointed staff to the Paediatric Services including medical practitioners and for those new to specific areas that include the following: a) explanation of the vision, mission, goals, objectives, policies and procedures of the Facility and those of the Paediatric Services; b) lines of authority and areas of responsibility; c) explanation of particular duties and functions; d) explanation of the methods of assigning clinical care and the standards of clinical practice; e) handover communication; f) information about safety procedures eg Needlestick Injury, Fire Safety; g) training in basic/advanced life support techniques eg. NRP, PLS etc; h) methods of obtaining appropriate resource materials ; i) education on Patient and Family Rights; j) education on MSQH Standards requirements. k) <table><tr><td rowspan="3">EVIDENCE OF COMPLIANCE</td><td>1. Policy requiring all new staff to attend a structured orientation programme.</td><td></td></tr><tr><td>2. There is Paediatric Services orientation programme with relevant topics not limited to topics covered from (a) to (l).</td><td></td></tr><tr><td>3. Attendance list</td><td></td></tr></table> Facility Comments:	EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme.		2. There is Paediatric Services orientation programme with relevant topics not limited to topics covered from (a) to (l).		3. Attendance list				
EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme.										
	2. There is Paediatric Services orientation programme with relevant topics not limited to topics covered from (a) to (l).										
	3. Attendance list										
9D.2.4.2	Organisations should have arrangements for the: a) promotion of staff well-being b) resolution of workplace issues										

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. The promotion of staff well-being may involve:			
		a) procedures to promote well-being, e.g. stress management, workload monitoring, management of worklife balance, healthy lifestyle programmes eg. BookDoc, KOSPEN			
		b) staff being provided with appropriate supervision, support and advice e.g. Mentor Mentee			
		2. The resolution of workplace issues may involve:			
		a) measures to protect staff against violence, bullying and harassment e.g. signage			
		b) clear procedures for the effective management of underperformance eg feedback on Sasaran Kerja Tahunan (SKT)			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT				
TOPIC 9D.3: POLICIES AND PROCEDURES				
STANDARD 9D.3.1 <i>DEVELOPMENT, DERIVATION AND DOCUMENTATION</i> <i>There are written and dated policies and procedures for all activities of the Paediatric Services. These policies and procedures reflect current standards of medical practice, relevant regulations, statutory requirements, and the purposes of the services. These policies and procedures, terms of reference, by-laws, rules or regulations, state how the clinical staff including medical practitioners regulate themselves and provide patient care.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT
				SURVEYOR RATING
9D.3.1.1 CORE	There are written policies and procedures for the Paediatric Services which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated. There is a mechanism for and evidence of a periodic review at least once in every three years.			
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for the service.		
		2. Policies and procedures are consistent with regulatory requirements and current standard practices.		
		3. Evidence of periodic review of policies and procedures.		
		4. The policies and procedures are endorsed and dated.		
	Facility Comments:			
9D.3.1.2	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved. Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.				
		2. Minutes of meeting with evidence of cross reference with other departments				
		3. Documented cross departmental policies				
		4. Attendance list of the relevant stakeholders in the meeting or committee				
	Facility Comments:					
9D.3.1.3 CORE	The policies and procedures documentation shall address at least the following topics and any others as required by relevant standards and laws: a) description of the organisational structure of the Paediatric Services; b) clinical practice guidelines; c) clinical documentation includes pain as the 5 th vital sign where appropriate; d) a paediatric patient shall not be placed in a room or ward with an adult patient preferably a female caregiver e) transition to adult care services (16-18 years old); f) assessment and care of newborn in postnatal ward; g) handover communication; h) drug prescription, dispensing and administration; i) blood transfusion; j) continuing of care including regular review of patient, review of investigation results, discharge (planned or At Own Risk), referrals and escort as necessary; k) pain management; l) management of cases with an infectious disease including notification of notifiable diseases; m) the responsibilities of the staff including medical practitioners in relation to internal and external disasters are documented, and known to the staff (contingency plan); n) incident reports shall be compiled, investigated, discussed and recorded and action plans implemented; o) risk management/patient safety and security; p) end of life care; q) management of a death.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures that address but not limited to (a) to (q).				
	Facility Comments:					
9D.3.1.4	Current policies and procedures are communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures- Attendance list / Minutes of meetings				
		2. Circulation list and signed acknowledgement of staff that have read the policies				
	Facility Comments:					
9D.3.1.5 CORE	There is evidence of compliance with policies and procedures.					
	EVIDENCE OF COMPLIANCE	1. Compliance with policies and procedures through:				
		a) interview of staff on practices;				
		b) verify with observation on practices;				
		c) results of audit on practices;				
		d) practices in line with established policies and procedures.				
	Facility Comments:					
9D.3.1.6	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.					
	EVIDENCE OF COMPLIANCE	1. Copies of relevant policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	
9D.3.1.7	The services shall operate on a 24-hour basis providing a level of care appropriate to the activities of the patients in the Facility.					
	EVIDENCE OF COMPLIANCE	1. Operational policy on 24-hour services				
		2. Staffing level reflects good mix of experienced staff and the intensity of activities during each shift.				
		3. On-call roster is dated and authorised.				
	Facility Comments:					

SURVEY ITEM &SELF-ASSESSMENT					
TOPIC 9D.4:		<u>FACILITIES AND EQUIPMENT</u>			
STANDARD <u>9D.4.1</u>		<i>The Head of Paediatric Services shall ensure adequate facilities and equipment that are safe and appropriate are available for the staff to function effectively and to meet the goals and objectives of the Paediatric Services.</i>			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9D.4.1.1	There are adequate and appropriate facilities and equipment with proper utilisation of space to enable staff to carry out their professional, teaching and administrative functions.				
	EVIDENCE OF COMPLIANCE	1. Adequate and proper utilisation of space.			
		2. Appropriate type of equipment to match the complexity of services.			
		3. Adequate facilities and equipment at each patient care area for safe care. (e.g. defibrillators, emergency cart, hand washing facilities, etc)			
		4. Bedding amenities for mother accompanying child during admission.			
		5. Easy access and clear exit routes			
		6. Absence of overcrowding			
	Facility Comments:				
9D.4.1.2	Facilities shall take cognizance of the design to ensure the safety of staff and patients. Refer a) Handbook Setting up of Private Hospitals in Malaysia 2019 Requirements and Procedures under Act 586, b) WHO Standards for improving the quality of care for children and young adolescents in health facilities				
	EVIDENCE OF COMPLIANCE	1. Design and layout of the unit, e.g. wards, treatment rooms, dirty and clean utility rooms, access, lighting, signage, etc address the safety aspects of patients and staff.			
		2. Adequate equipment and supplies for Paediatric Services, e.g. emergency trolley, functioning patient call bell etc.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		3. Equipment should have scheduled planned preventive maintenance (PPM).				
		4. Toilet facilities are adequate, user and disabled friendly e.g. - grab-bar and nurse call system for disable friendly - clear opening with patient's toilet door ≥0.9 m and must not swing inward or into corridor				
	Facility Comments:					
9D.4.1.3	Suitable and adequate forms of communication and intercommunication systems and equipment are provided to enable clinical staff to communicate among themselves and with the other members of the healthcare team.					
EVIDENCE OF COMPLIANCE	1. Appropriate telecommunication modalities available for daily operation and during emergencies. 2. Medical Alert Systems e.g. Code Blue System					
Facility Comments:						

SURVEY ITEM &SELF-ASSESSMENT						
STANDARD 9D.4.2	<u>FACILITIES AND EQUIPMENT FOR PATIENT CARE</u> <i>Adequate facilities and equipment shall be available to provide safe and effective patient care.</i>					
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9D.4.2.1	Facilities are suitably located to facilitate easy access and to provide an atmosphere of user, environmental and ‘disabled’ friendly.					
	EVIDENCE OF COMPLIANCE	1. Floor plan indicates accessibility and patient and user friendly.				
		2. Feedback from patient satisfaction survey				
		3. Incident reporting relating to facilities if any				
	Facility Comments:					
9D.4.2.2	Where the daily census requires ten (10) beds or more, a paediatric patient care unit shall be established as per regulatory requirements.					
	EVIDENCE OF COMPLIANCE	1. Separate paediatric care unit established to treat paediatric inpatients where the daily census required ten (10) beds or more.				
	Facility Comments:					
9D.4.2.3	Equipment, both for emergency and non-emergency usage, shall be appropriate to the level of care and of varying sizes including monitoring devices.					
	EVIDENCE OF COMPLIANCE	1. Availability of emergency and non-emergency equipment appropriate to level of care, such as defibrillator, emergency trolley, suction machine, electrocardiogram (ECG) machine, infusion or syringe pump, vital sign monitor, etc.				
		2. Scheduled checking of items in emergency trolley				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
9D.4.2.4	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.							
	EVIDENCE OF COMPLIANCE	1. Testing, commissioning and calibration records (certificates or stickers)						
		2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as evidence of compliance to the relevant standards and Acts.						
		Facility Comments:						
9D.4.2.5 CORE	There is evidence that the facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.							
	EVIDENCE OF COMPLIANCE	1. Planned Preventive Maintenance records such as schedule, stickers, etc.						
		2. Planned Replacement Programme where applicable						
		3. Complaint records						
		4. Asset inventory						
	Facility Comments:							
9D.4.2.6	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.							
	EVIDENCE OF COMPLIANCE	1. User training records						
		2. Competency assessment record						
		3. Letter of authorisation						
		4. List of staff trained and authorised to operate specialised equipment						
	Facility Comments:							
9D.4.2.7	Equipment is upgraded (based on evidence) from time to time so as to keep pace with advancement in operative and diagnostic techniques and technology.							

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Equipment are being replaced and upgraded to meet current standard of care and advancement in technology in a planned and systematic manner.				
	Facility Comments:					
9D.4.2.8 CORE	A Special Care Nursery may be located within a pediatric care unit for smaller Facility without Neonatal Intensive Care Unit (NICU) with the following features: a) it shall be sufficiently large so that the bassinet would stand 15.2cm from the wall and partitioned and be spaced at least 0.3metres apart and aisles used for passageway shall be at least 0.9metres width; b) storage space for the individual newborn supplies in a compartment in bassinets or on individual table; c) the equipment provided shall include: i) easily cleaned bassinet for each newborn; ii) incubator and radiant warmer; iii) accurate easily cleaned weighing scales; iv) piped oxygen and compressed air with outlets, one for every four bassinets, where applicable; d) elbow, knee, foot or automatically operated clinical hand washing facility with mixing faucet; e) sanitary hand-drying facility; f) disposable areas for diaper and soil linen. g) Emergency equipment such as pulse oximeter, oxygen blender, positive pressure ventilation device/ T-piece resuscitator and transport incubator					
EVIDENCE OF COMPLIANCE	1. Where Special Care Nursery is established the unit includes features as stated in (a) to (f).					
Facility Comments:						

SURVEY ITEM & SELF-ASSESSMENT																					
STANDARD 9D.4.3	<u>FACILITIES FOR PAEDIATRIC OUTPATIENT SERVICES</u> <i>Where specialist outpatient services are provided, there are adequate outpatient clinics to enable the provision of safe and effective patient care, and patient privacy and confidentiality are assured.</i>																				
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS																		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING																	
9D.4.3.1	The Specialist Outpatient Services shall have the following features: a) the organisation and management of the clinics are planned so as to ensure prompt attention to patients, minimal waiting time, and avoidance of unnecessary visits by the patients; b) record keeping shall be efficient; c) an appointment or queuing system is used to manage patient consultations; d) the clinic is easily accessible including for non-ambulant patients and is easily identified through adequate signage; e) the clinic is located close to other facilities, e.g. radiology, laboratories and pharmacy; f) adequate provision is made for patient comfort; g) nursing and nappy change area; h) children play area; i) facilities for the disabled.																				
	<table><tr><td rowspan="8">EVIDENCE OF COMPLIANCE</td><td colspan="2">1. The Specialist Outpatient Services address (a) to (i) with evidence of but not limited to the following:</td></tr><tr><td>a) list of services available and offered to patients;</td><td></td></tr><tr><td>b) flow chart on work process;</td><td></td></tr><tr><td>c) safe keeping of medical records;</td><td></td></tr><tr><td>d) security of data in Health Information System;</td><td></td></tr><tr><td>e) clinic appointment system;</td><td></td></tr><tr><td>f) monitoring of waiting time;</td><td></td></tr><tr><td>g) adequate and appropriate signage;</td><td></td></tr></table>	EVIDENCE OF COMPLIANCE	1. The Specialist Outpatient Services address (a) to (i) with evidence of but not limited to the following:		a) list of services available and offered to patients;		b) flow chart on work process;		c) safe keeping of medical records;		d) security of data in Health Information System;		e) clinic appointment system;		f) monitoring of waiting time;		g) adequate and appropriate signage;				
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	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		h) floor plan indicates accessibility to supporting services and optimisation of space;				
		i) adequate patient personal use items, e.g. wheelchair, etc;				
		j) adequate waiting area, rest rooms, reading material and parking space.				
	Facility Comments:					
9D.4.3.2	Adequate numbers of rooms are provided to ensure patient privacy and confidentiality for various patient care activities including: a) consultation (not more than one patient in a room at any time); b) conduct of minor procedures and nursing procedures; maintain a register of procedures performed; c) performance of various tests.					
EVIDENCE OF COMPLIANCE	1. Adequate facilities for consultation and patient care activities that address (a) to (c) with evidence of but not limited to the following:					
	a) privacy of patient is ensured;					
	b) procedure room appropriately equipped;					
	c) patient monitoring device is available where required;					
	d) list of procedures done.					
Facility Comments:						

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 9D.5:		<u>SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES</u>				
STANDARD <u>9D.5.1</u>		<i>The Head of Paediatric Services shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Paediatric Services. The Head of Paediatric Services shall ensure compliance to monitoring of specific performance indicators.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9D.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Paediatric Services. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.					
EVIDENCE OF COMPLIANCE	1.	Planned performance improvement activities include (a) to (f)				
	2.	Records on performance improvement activities				
	3.	Minutes of performance improvement meetings				
	4.	Performance improvement studies				
	5.	Mortality and morbidity audits with remedial actions				
	6.	Records on innovation if available.				
Facility Comments:						
9D.5.1.2	The Head of Paediatric Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement activities to appropriate individual/personnel within the respective services.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes of meetings				
		2. Letter of assignment of responsibilities				
		3. Job description				
	Facility Comments:					
9D.5.1.3	The Head of Paediatric Services shall ensure that the staff are adequately trained in performance improvement activities eg. Key Performance Indicators and Incident Reporting					
	EVIDENCE OF COMPLIANCE	1. System for performance activities is in place, which include:				
		a) Training of staff				
		b) Policy on the performance activity				
		c) Methodology				
		d) Register/records of incidents or shortfalls				
		2. Corrective and preventive action plans				
		3. Remedial measure				
		4. Minutes of meetings				
		5. Acknowledgment by Head of Service and PIC/Hospital Director				
		6. Feedback given to staff regarding incident reporting / shortfalls.				
	Facility Comments:					
9D.5.1.4 CORE	The staff including medical practitioners provide an appropriate peer group structure for performing the safety and performance improvement activities to accomplish clinical care evaluation. a) The medical practitioners undertake clinical reviews of all risk assessments, incident reports, audits and safety and performance improvement activities: i) as a single committee for all safety and performance improvement activities; ii) in multidisciplinary committees within the service;					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS										
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING									
	iii) in a variety of purpose-specific committees, such as mortality and morbidity, infection control, blood transfusion, etc. b) Whatever structure is utilised, provision is made for review and analysis of the clinical work of each individual clinical service, department, unit or function.												
	<table><tr><td rowspan="3">EVIDENCE OF COMPLIANCE</td><td>1. Performance improvement activities</td><td></td></tr><tr><td>2. Minutes of meetings</td><td></td></tr><tr><td>3. Relevant reports and documents, e.g. clinical audit reports, incident reports, mortality and morbidity review reports, etc.</td><td></td></tr></table>	EVIDENCE OF COMPLIANCE	1. Performance improvement activities		2. Minutes of meetings		3. Relevant reports and documents, e.g. clinical audit reports, incident reports, mortality and morbidity review reports, etc.						
EVIDENCE OF COMPLIANCE	1. Performance improvement activities												
	2. Minutes of meetings												
	3. Relevant reports and documents, e.g. clinical audit reports, incident reports, mortality and morbidity review reports, etc.												
	Facility Comments:												
9D.5.1.5 CORE	There is tracking and trending of specific performance indicators not limited to but at least three (3) of the following: a) number of mortality/morbidity audits/meetings being conducted in the department with documentation of cases discussed b) percentage of unplanned readmission for the same condition within 48 hours of discharge (Target: ≤2%) c) community acquired pneumonia death rate in previously healthy children aged between one (1) month and five (5) years. (Target: ≤1%) d) Percentage of patients with waiting time of ≤ 90 minutes to see the doctor at Paediatric Specialist Clinic (Target: ≥ 90%) e) Percentage of survival of inborn very low birth weight infants between 1000 – 1499 g birth weight. (Target: 90%) Refer TECHNICAL SPECIFICATIONS FOR KEY PERFORMANCE INDICATORS (KPI) CLINICAL SERVICES MEDICAL PROGRAMME 2019												
	<table><tr><td rowspan="4">EVIDENCE OF COMPLIANCE</td><td>1. Specific performance indicators monitored.</td><td></td></tr><tr><td>2. Records on tracking and trending analysis.</td><td></td></tr><tr><td>3. Reports of mortality/morbidity audits meetings</td><td></td></tr><tr><td>4. Remedial measures taken where appropriate</td><td></td></tr></table>	EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored.		2. Records on tracking and trending analysis.		3. Reports of mortality/morbidity audits meetings		4. Remedial measures taken where appropriate				
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	Facility Comments:												

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS			
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
9D.5.1.6	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.						
	EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff.					
		2. Evidence of feedback via communication on results of performance improvement activities through continuing medical education/meetings.					
		3. Minutes of service/unit/committee meetings					
	Facility Comments:						
9D.5.1.7	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.						
	EVIDENCE OF COMPLIANCE	1. Documentation on performance improvement activities and performance indicators.					
		2. Policy statement on anonymity on patients and providers involved in performance improvement activities.					
	Facility Comments:						
9D.5.1.8	Organisations should develop, review and test a disaster recovery plan. The disaster could be natural (e.g. floods, earthquakes, hurricanes, disease outbreaks), or manmade (e.g. urban fires, industrial accidents, bioterrorism).						
	EVIDENCE OF COMPLIANCE	1. Documentation on training of emergency or contingency plan					
		2. Attendance list					
		3. Evidence of practice drills eg fire drills					
		4. Scheduling of drills in the organization's annual plan					
	Facility Comments:						
9D.5.1.9	Validation process eg audits for performance improvement activities shall be conducted by the first and second parties. First party audit shall be performed within the organization Second party audit is by an external party validating the processes of the organization						

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	EVIDENCE OF COMPLIANCE	1. Reports of first and second party audits being carried out. Example of First party audits e.g. internal audit for KPI or ISO being carried out				
		a) Reports on organization performance e.g. KPI				
		b) Reports on compliance or conformance of the organization e.g. Incident reports and ISO				
		c) Documentation of any remedial measures being carried out				
		d) Corrective and preventive action plans in place				
		e) Acknowledgement of Head of the Facility regarding the first party audit results and actions taken				
		2. Second Party Audit is by a certified external organization to ensure the organization' compliance and conformance e.g. SIRIM for ISO, Ministry of Health for KPI				
	Facility Comments:					

SURVEYOR SUMMARY:

OVERALL RISK:

SURVEY ITEM & SELF-ASSESSMENT				
SERVICE STANDARD 9E : CLINICAL SERVICES - CARDIOLOGY SERVICES				
	PREAMBLE <i>The Cardiology Services shall be organised, directed and coordinated with other services in the Facility to provide a high standard of inpatient and outpatient care to the community and cover the following but not limited to:-</i> a) <i>appropriateness of clinical care</i> b) <i>unwarranted variation in care that is not explained by the clinical circumstances or personal choices of the medical practitioners in:-</i> i) <i>overuse of treatments or procedures that do not help patients get better;</i> ii) <i>underuse of care;</i> iii) <i>misuse (or errors) of doing something incorrectly and harming patients.</i>			
TOPIC 9E.1: STANDARD 9E.1.1	ORGANISATION AND MANAGEMENT <i>The Cardiology Services shall be organised, directed and coordinated with other services in the Facility to provide a high standard of inpatient and outpatient care to the community in a safe, efficient, effective, evidence based and caring manner with due regard for the needs, dignity and privacy of patients and confidentiality of their personal information. The Cardiology Services shall be easily accessible and continuity of care assured.</i>			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT
				SURVEYOR RATING
9E.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Cardiology Services are clearly documented and measurable that indicates safety, quality and patient centred care. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.			
	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.		
		2. Goals and objectives of the Cardiology Services in line with the Facility statements are available, endorsed and dated.		

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		3. Evidence of planned reviews of the above statements.				
		4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)				
		5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.				
	Facility Comments:					
9E.1.1.2 CORE	There is an organisation chart which:					
	a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head of Cardiology Services, consultants, medical practitioners and staff of the Cardiology Services;					
	b) is accessible to all staff and clients;					
	c) is revised when there is a major change in any of the following:					
	i) organisation;					
	ii) functions;					
	iii) reporting relationships;					
	iv) staffing patterns.					
	EVIDENCE OF COMPLIANCE	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head of Cardiology Services, consultants, medical practitioners and staff of the Cardiology Services.				
		2. Organisation chart of the service is endorsed, dated and accessible.				
		3. The organisation chart is revised when there is a major change in any of the items (c)(i) to (iv).				
	Facility Comments:					
9E.1.1.3	The Governing Body shall ensure that the Cardiology Services are organised in such a way as to:					
	a) facilitate the provision of cardiology services to patients in the Facility in a safe, efficient, effective, and caring manner and with due regard for the needs, dignity and privacy of patients and confidentiality of their personal information;					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	b) assure continuity of care; c) address the professional needs of the cardiologist; d) ensure that the cardiologists are involved in the formulation of policies and procedures concerning patient care appropriate to the scope of services of the Facility.				
	EVIDENCE OF COMPLIANCE	1. Departmental/Service operational policies that address (a) to (d).			
		2. Medical Staff By-Laws			
		3. Evidence of involvement of cardiologists in the formulation of policies and procedures concerning patient care.			
		4. Involvement of Head of the Service in the Medical and Dental Advisory Committee/Medical Advisory Committee and ward meetings.			
		5. Minutes of meetings			
		6. Proper and adequate equipment according to current standards.			
	Facility Comments:				
9E.1.1.4	There is a mechanism to ensure effective interaction between the Cardiology Services and the Governing Body on all clinical aspects of healthcare and other relevant matters in the Facility. This mechanism is defined in the policies of the Governing Body and may be accomplished through: a) the appointment/assignment of a cardiologist as the Head of Cardiology Services delineating his/her authority, responsibilities and accountabilities in a written document according to the relevant Acts to manage and control the Cardiology Services; b) Medical and Dental Advisory Committee (MDAC) to advise the Governing Body on issues related to clinical governance, i.e. planning, coordinating, implementation, control and to improve activities relating to Cardiology Services.				
	EVIDENCE OF COMPLIANCE	1. Letter of appointment/assignment and delineation of duties and responsibilities of the Head of the Service.			
		2. Letter of appointment and Terms of Reference as member of the Medical and Dental Advisory Committee/Medical Advisory Committee.			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	3. Minutes of meetings of MDAC/Management				
	Facility Comments:				
9E.1.1.5 CORE	The Head of Cardiology Services has: a) representation of the Service in committees and subcommittees where relevant; b) representation of the Service in clinical staff liaison meetings; c) involvement and provide regular input to the Senior Management Team.				
	EVIDENCE OF COMPLIANCE	1. Letter of representation of the Head of Service in committees and subcommittees where relevant, e.g. Blood Transfusion Committee, Medical Records Committee, Hospital Infection and Antibiotic Control Committee, etc.			
		2. Minutes of meetings of committees			
		3. Minutes of meeting of Senior Management Team.			
	Facility Comments:				
9E.1.1.6	The assessment, planning, direction, evaluation and continuity of clinical care are the responsibility of cardiologists managing their patients, thus ensuring clinical independence.				
	EVIDENCE OF COMPLIANCE	1. Documentation of departmental policy and procedures			
		2. Medical Staff By-Laws; clause indicate clinical care responsibility of cardiologist.			
		3. Documented evidence of clinical notes in the patient's medical record; e.g. documentation on assessment, planning, direction, evaluation and continuity of clinical care, valid name stamp of cardiologists/medical practitioners.			
	Facility Comments:				
9E.1.1.7	The Head of Cardiology Services shall be involved for the following aspects of management of the services: a) the preparation of budget and ensuring that expenditure remains within the budget allocated;				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	b) human resource management and development including maintaining credentialing and experience of all staff – cardiologists/medical practitioners, nurses and technologists; c) development of policies and procedures and ensuring compliance to them; d) facility and equipment management; e) safety and performance improvement activities and risk management.					
	EVIDENCE OF COMPLIANCE				1. Evidence of (a) to (e) in the minutes of meetings of Cardiology Services indicate the involvement of Head of Service.	
					2. Request for allocation of budget and staffing	
					3. Credentialing and privileging process for staff	
					4. Endorsement of policies and procedures	
					5. Implementation of performance improvement activities	
	Facility Comments:					
9E.1.1.8	Regular staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Cardiology Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.					
EVIDENCE OF COMPLIANCE	1. Minutes are accessible, disseminated and acknowledged by the staff.					
	2. Attendance list of members with adequate representatives of the service.					
	3. Frequency of meetings as scheduled.					
	4. Discussion and resolutions are implemented. (Problems not solved to be brought forward in the next meeting until resolved).					
Facility Comments:						
9E.1.1.9	Where there are medical practitioners, nurses and paramedics in cardiology training, there is evidence that: a) their responsibilities for patient care are documented; b) their training needs are identified;					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	c) appropriate supervision and training are given to the medical practitioners, nurses and paramedics concerned.					
	EVIDENCE OF COMPLIANCE	1. Structured training programmes for medical practitioners, nurses and paramedics are in place.				
		2. Training timetable, continuing medical education and attendances list				
		3. Assessment reports				
		4. Log books				
	Facility Comments:					
9E.1.1.10	Appropriate statistics and records shall be maintained in relation to the provision of Cardiology Services and used for managing the services and patient care purposes.					
EVIDENCE OF COMPLIANCE	1. Records are available but not limited to the following:					
	a) monthly submission of all Acute Coronary Syndrome (ACS) and Percutaneous Coronary Intervention (PCI) cases to National Cardiovascular Disease Database (NCVD) Registry;					
	b) yearly volume of Percutaneous Coronary Interventions (PCIs) and other interventional procedures for the Facility;					
	c) yearly volume of PCIs and other interventional procedures for individuals;					
	d) outcomes of PCIs and other interventional procedures for Facility/individuals based on statistics of services and patient care are managed accordingly;					
	e) accident/incident reports;					
	f) staffing number and staff profile;					
	g) staff training records;					
	h) data on performance improvement activities, including performance indicators					
Facility Comments:						

SURVEY ITEM & SELF-ASSESSMENT				
TOPIC 9E.2	<u>HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT</u>			
STANDARD 9E.2.1	<u>CREDENTIALING AND PRIVILEGING</u> <i>The Cardiology Services shall be directed by a qualified and competent Cardiologist and staffed by suitably qualified and competent clinical staff to achieve the goals and objectives of the services.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9E.2.1.1 CORE	There is documented evidence of appropriate training and competency for the granting of clinical privileging. The criteria for determining privileges are specified and documented. There is a structured process to ensure the stated criteria are uniformly applied to all applicants. These include:			
	a) the criteria are designed to assure that patients will receive safe and quality care; b) the criteria for individual procedures are documented in detail; e.g. competency records/log books, application from the individual practitioner, recommendations from peer/referee and minutes of meeting; c) competency for each performance is dated, verified and signed by the supervisors; d) the period of time for which the privileges are to be granted is specified; e) current registration with the local professional registration bodies, e.g. Malaysian Medical Council, National Specialist Register (NSR); f) peer recommendations are taken into account when privileges are being considered; g) the recommendations of the relevant department and/or major professional services for privileges to be granted are taken into consideration.			
	1. Documented policies and procedures are established to govern the credentialing and privileging processes which include items (a) to (g).			
	2. Compliance with policy and criteria for credentialing and privileging			
	3. Annual Practising Certificate (APC), National Specialist Register (NSR) certificate and privileging certificate.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		4. Recommendations from peer/referee				
		5. Availability of the list of procedures requiring privileging				
		6. Availability of list of procedures to include core procedures specific to the disciplines performed by medical officers; competency records/log books				
	Facility Comments:					
9E.2.1.2 CORE	For Facility identified as Cardiology Training Centre There is documented evidence of appropriate training and competency for certification. The criteria for determining for certification are specified and documented. There is a structured process to ensure the stated criteria are uniformly applied. These include: a) the criteria are designed to assure that patients will receive safe and quality care; b) the criteria for individual procedures are documented in detail; e.g. competency records/log books, application from the individual practitioner, recommendations from peer/referee and minutes of meeting; c) competency for each performance is dated, verified and signed by the supervisors; d) the period of time for which the privileges are to be granted is specified; e) current registration with the local professional registration bodies, e.g. Malaysian Medical Council, National Specialist Register (NSR); f) peer recommendations are taken into account when privileges are being considered; g) the recommendations of the relevant department and/or major professional services for privileges to be granted are taken into consideration.					
EVIDENCE OF COMPLIANCE	1. Documented policies and procedures are established to govern the credentialing and privileging processes which include items (a) to (g).					
	2. Compliance with policy and criteria for credentialing and privileging					
	3. Recommendations from peer/referee					
	4. Competency records/log books					
	5. Annual Practising Certificate (APC) and privileging certificate					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		6. Availability of the list of procedures requiring privileging.				
		7. Availability of list of procedures to include core procedures specific to the disciplines performed by medical officers.				
9E.2.1.3 CORE	Documented evidence of privileges conferred by the Governing Body is available and accessible to relevant staff at point of care.					
	EVIDENCE OF COMPLIANCE	1. Formal letter of assignment or certificate of privileging with stipulated timeline are issued and reviewed accordingly.				
		2. Updated list of staff with privileges conferred is made accessible at point of care.				
	Facility Comments:					
9E.2.1.4	Clinical staff performs procedures within the privileges conferred.					
	EVIDENCE OF COMPLIANCE	1. Verification of procedures performed by individuals at point of care within the awarded privileging rights with evidence of:				
		a) list of procedures privileged;				
		b) clinical notes.				
	Facility Comments:					
9E.2.1.5	There are written and dated specific job descriptions for all categories of staff that include: a) qualifications, training, experience and certification required for the position; b) lines of authority; c) accountability, functions, and responsibilities; d) reviewed when required and when there is a major change in any of the following: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations. e) administrative and clinical functions.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e).				
		2. Job description includes specialisation skills				
		3. Relevant privileges granted where applicable				
		4. The job description is acknowledged by the staff and signed by the Head of Service and dated.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
STANDARD 9E.2.2	<i>STAFF TRAINING, EDUCATION, APPRAISAL AND RESEARCH</i> <i>The Facility and all staff shall demonstrate an ongoing commitment to continuing medical education.</i>					
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9E.2.2.1	There are continuing education activities for staff including cardiologists to pursue professional interests and to prepare for current and future changes in practice.					
	EVIDENCE OF COMPLIANCE	1. Training calendar includes in-house/external courses/workshop/conferences				
		2. Contents of training programme				
		3. Training records on continuing education activities are kept and maintained for each staff including training in life support.				
		4. Certificate of attendance/degree/post basic training				
	Facility Comments:					
9E.2.2.2	The educational needs of staff and the Facility, as evidenced by the results of medical-care evaluation such as incident reports, performance improvement studies and complaints, are taken into consideration when the content and structure of educational activities are planned and implemented.					
	EVIDENCE OF COMPLIANCE	1. Evidence of inclusion of results of audit activities, e.g. mortality and morbidity reviews, incident reporting, etc in educational activities.				
		2. Evidence of improvement made from corrective or preventive measures from incident reports.				
	Facility Comments:					
9E.2.2.3	In a Facility where undergraduate medical, nursing and allied health training programmes are conducted, the Facility shall ensure that there are sufficient skilled trained staff to provide clinical supervision of students.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Sufficient skilled trained staff to provide clinical supervision as per terms of Memorandum of Understanding.				
	Facility Comments:					
9E.2.2.4	There is evidence of training needs assessment and staff development plan which provides the knowledge and skills required for staff to maintain competency in their current positions and future advancement.					
	EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and gaps identified.				
		2. A staff development plan based on training needs assessment is available.				
		3. Training schedule/calendar is in place.				
		4. Training module				
	Facility Comments:					
9E.2.2.5	Staff including cardiologists receive written evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.					
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff including cardiologists is completed upon probationary period and as an annual exercise.				
	Facility Comments:					
9E.2.2.6	Where appropriate the Facility shall endeavour to undertake clinical research using available resources.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Documented evidence of research activities e.g. protocol, policies, consent etc.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT															
STANDARD 9E.2.3	STAFFING LEVEL AND STAFF COMPETENCY <i>The Head and staff of the Cardiology Services including cardiologists are individuals qualified by education, training and experience commensurate with the requirements of the various positions and relevant laws.</i>														
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS												
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING											
9E.2.3.1	Deployment of all service providers for the Cardiology Services takes the following factors into consideration: a) the number of persons deployed is proportional to the number of patients being cared for as in regulatory requirements and also the intensity of care provided; b) the categories of service providers based on qualifications and experience providing care reflect the complexity of clinical problems being managed; c) staffing needs shall take into consideration absences due to leave or illness; double shift duties by clinical staff shall be documented and monitored; d) adequate staffing levels of appropriate competency shall be maintained throughout the hours the services are in operation. Where services need to be provided on a 24-hour basis, staffing level reflects the intensity of activities during each shift; e) where it is not possible to have service providers on duty on site, e.g. after working hours, provision is made for relevant staff to be available on call.														
	<table border="1"> <tr> <td rowspan="5">EVIDENCE OF COMPLIANCE</td> <td colspan="2">1. Documentation and planning on deployment of staff that includes but not limited to (a) to (e) with evidence of:</td> </tr> <tr> <td>a) deployment based on staff to patient ratio, bed occupancy rate and complexity of cases;</td> <td></td> </tr> <tr> <td>b) special skills/training of staff;</td> <td></td> </tr> <tr> <td>c) contingency plan during acute shortage;</td> <td></td> </tr> <tr> <td>d) duty roster.</td> <td></td> </tr> </table>	EVIDENCE OF COMPLIANCE	1. Documentation and planning on deployment of staff that includes but not limited to (a) to (e) with evidence of:		a) deployment based on staff to patient ratio, bed occupancy rate and complexity of cases;		b) special skills/training of staff;		c) contingency plan during acute shortage;		d) duty roster.				
EVIDENCE OF COMPLIANCE	1. Documentation and planning on deployment of staff that includes but not limited to (a) to (e) with evidence of:														
	a) deployment based on staff to patient ratio, bed occupancy rate and complexity of cases;														
	b) special skills/training of staff;														
	c) contingency plan during acute shortage;														
	d) duty roster.														
	Facility Comments:														

SURVEY ITEM & SELF-ASSESSMENT											
STANDARD 9E.2.4	STAFF ORIENTATION <i>A structured orientation programme introduces new staff to their services, operational policies and relevant aspects of the Facility to prepare them for their roles and responsibilities.</i>										
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS								
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING							
9E.2.4.1	There is a structured orientation programme for all newly appointed staff to the Cardiology Services including cardiologists and for those new to specific areas that include the following: a) explanation of the goals, objectives, policies and procedures of the Facility and those of the Cardiology Services; b) lines of authority and areas of responsibility; c) explanation of particular duties and functions; d) explanation of the methods of assigning clinical care and the standards of clinical practice; e) handover communication; f) processes for resolving practice dilemmas in timely manner; g) information about safety procedures; h) training in basic/advanced life support techniques; i) methods of obtaining appropriate resource materials; j) staff appraisal procedures for the Cardiology Services; k) education on Patient and Family Rights; l) education on MSQH Standards requirements.										
	<table><tr><td rowspan="3">EVIDENCE OF COMPLIANCE</td><td>1. Policy requiring all new staff to attend a structured orientation programme.</td><td></td></tr><tr><td>2. There is Cardiology Services orientation programme with relevant topics not limited to topics covered from (a) to (l).</td><td></td></tr><tr><td>3. Attendance list</td><td></td></tr></table>	EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme.		2. There is Cardiology Services orientation programme with relevant topics not limited to topics covered from (a) to (l).		3. Attendance list				
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	3. Attendance list										
	Facility Comments:										

SURVEY ITEM & SELF-ASSESSMENT							
TOPIC 9E.3:		<u>POLICIES AND PROCEDURES</u>					
STANDARD 9E.3.1		<u>DEVELOPMENT, DERIVATION AND DOCUMENTATION</u> <i>There are written and dated policies and procedures for all activities of the Cardiology Services. These policies and procedures reflect current standards of medical practice, relevant regulations, statutory requirements, and the purposes of the services. These policies and procedures, terms of reference, by-laws, rules or regulations, state how the clinical staff and cardiologists regulate themselves and provide patient care. There should be a list of procedures requiring informed consent specific to cardiology. Possible risks and complications arising from procedures should be documented either in specific consent forms or in patient's records.</i>					
		CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9E.3.1.1 CORE	There are written policies and procedures for the Cardiology Services which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated.						
	There is a mechanism for and evidence of a periodic review at least once in every three years.						
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for the service.					
		2. Policies and procedures are consistent with the regulatory requirements and current standard practices.					
		3. Evidence of periodic review of policies and procedures.					
		4. The policies and procedures are endorsed and dated.					
Facility Comments:							
9E.3.1.2	Policies and procedures are developed by a committee in collaboration with staff, cardiologists, Management and where required with other external service providers and with reference to relevant sources involved.						
Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.							

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.				
		2. Minutes of meeting with evidence of cross reference with other departments				
		3. Documented cross departmental policies				
		Facility Comments:				
9E.3.1.3 CORE	The policy and procedure documentation shall cover at least the following topics and any others required by law: a) description of the organisation structure of the Cardiology Services; b) clinical practice guidelines; c) clinical documentation includes pain as the 5 th vital sign where appropriate; d) handover communication; e) drug prescription, dispensing and administration; f) blood transfusion; g) continuing of care including regular review of patient, review of investigation results, discharge (planned or At Own Risk), referrals and escort as necessary; h) pain management; i) management of patients under police custody/prisoner; j) management of cases with an infectious disease including notification of notifiable diseases; k) the responsibilities of the staff including cardiologist in relation to internal and external disasters are documented, and known to the staff (contingency plan); l) incident reports shall be compiled, investigated, discussed, and recorded and action plans implemented; m) transfer protocol for patients who require emergency surgery at facility without on-site cardiothoracic surgery backup; n) end of life care; o) management of a death.					
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures that address but not limited to (a) to (o).				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9E.3.1.4	Current policies and procedures are communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings				
		2. Circulation list and acknowledgement				
		Facility Comments:				
9E.3.1.5 CORE	There is evidence of compliance with policies and procedures.					
	EVIDENCE OF COMPLIANCE	1. Compliance with policies and procedures through:				
		a) interview of staff on practices;				
		b) verify with observation on practices;				
		c) results of audit on practices;				
		d) practices in line with established policies and procedures.				
	Facility Comments:					
9E.3.1.6	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.					
	EVIDENCE OF COMPLIANCE	1. Copies of relevant policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.				
		Facility Comments:				
9E.3.1.7	The Cardiology Services shall operate on a 24-hour basis providing a level of care appropriate to the activities of the patients in the Facility. Where treatment facilities are not available on a 24-hour basis, there is a written policy for referral of patients to the nearest facilities where such facilities exist to render optimum treatment to the patient.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Operational policy on 24-hour services				
		2. Staffing level reflects good mix of experienced staff and the intensity of activities during each shift.				
		3. On-call roster is dated and authorised.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 9E.4: FACILITIES AND EQUIPMENT						
STANDARD 9E.4.1		The Head of Cardiology Services shall ensure adequate facilities and equipment that are safe and appropriate are available for the staff to function effectively and to meet the goals and objectives of the Cardiology Services.				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9E.4.1.1	There are adequate and appropriate facilities and equipment with proper utilisation of space to enable staff to carry out their professional, teaching and administrative functions.					
	EVIDENCE OF COMPLIANCE	1. Adequate and proper utilisation of space.				
		2. Appropriate type of equipment to match the complexity of services.				
		3. Adequate facilities and equipment at each patient care area for safe care. (e.g. defibrillators, emergency cart, hand washing facilities etc)				
		4. Easy access and clear exit routes				
		5. Absence of overcrowding				
	Facility Comments:					
9E.4.1.2	Existing facilities shall take cognisance of the safety of staff and patients.					
	EVIDENCE OF COMPLIANCE	1. Design and layout of the unit, e.g. wards, treatment rooms, dirty and clean utility rooms, access, lighting, signage, etc address the safety aspects of patients and staff.				
		2. Adequate equipment and supplies for Cardiology Services, e.g. emergency trolley, functioning patient call bell, etc.				
		3. Equipment should have scheduled planned preventive maintenance (PPM).				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9E.4.1.3	Suitable and adequate forms of communication and intercommunication systems and equipment are provided to enable clinical staff to communicate among themselves and with the other members of the healthcare team.				
	EVIDENCE OF COMPLIANCE	1. Appropriate telecommunication modalities available for daily operation and during emergencies.			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT														
STANDARD 9E.4.2	FACILITIES AND EQUIPMENT FOR PATIENT CARE Adequate facilities and equipment shall be available to provide safe and effective patient care.													
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS											
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING										
9E.4.2.1	Facilities are suitably located to facilitate easy access and to provide an atmosphere of user, environmental and 'disabled' friendly. <table border="1"> <tr> <td rowspan="3">EVIDENCE OF COMPLIANCE</td> <td>1. Floor plan indicates accessibility and patient and user friendly.</td> <td></td> </tr> <tr> <td>2. Feedback from patient satisfaction survey</td> <td></td> </tr> <tr> <td>3. Incident reporting relating to facilities if any.</td> <td></td> </tr> <tr> <td colspan="3">Facility Comments:</td> </tr> </table>	EVIDENCE OF COMPLIANCE	1. Floor plan indicates accessibility and patient and user friendly.		2. Feedback from patient satisfaction survey		3. Incident reporting relating to facilities if any.		Facility Comments:					
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	3. Incident reporting relating to facilities if any.													
Facility Comments:														
9E.4.2.2	Equipment, both for emergency and non-emergency usage, shall be appropriate to the level of care. <table border="1"> <tr> <td rowspan="2">EVIDENCE OF COMPLIANCE</td> <td>1. Availability of emergency and non-emergency equipment appropriate to level of care, such as defibrillator, emergency trolley, suction machine, electrocardiogram (ECG) machine, infusion or syringe pump, vital sign monitor, etc.</td> <td></td> </tr> <tr> <td>2. Scheduled checking of items in emergency trolley</td> <td></td> </tr> <tr> <td colspan="3">Facility Comments:</td> </tr> </table>	EVIDENCE OF COMPLIANCE	1. Availability of emergency and non-emergency equipment appropriate to level of care, such as defibrillator, emergency trolley, suction machine, electrocardiogram (ECG) machine, infusion or syringe pump, vital sign monitor, etc.		2. Scheduled checking of items in emergency trolley		Facility Comments:							
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	2. Scheduled checking of items in emergency trolley													
Facility Comments:														
9E.4.2.3	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements. <table border="1"> <tr> <td rowspan="2">EVIDENCE OF COMPLIANCE</td> <td>1. Testing, commissioning and calibration records (certificates or stickers)</td> <td></td> </tr> <tr> <td>2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as evidence of compliance to the relevant standards and Acts.</td> <td></td> </tr> <tr> <td colspan="3">Facility Comments:</td> </tr> </table>	EVIDENCE OF COMPLIANCE	1. Testing, commissioning and calibration records (certificates or stickers)		2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as evidence of compliance to the relevant standards and Acts.		Facility Comments:							
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Facility Comments:														

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9E.4.2.4 CORE	There is evidence that the facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.					
	EVIDENCE OF COMPLIANCE	1. Planned Preventive Maintenance records such as schedule, stickers, etc.				
		2. Planned Replacement Programme where applicable.				
		3. Complaint records				
		4. Asset inventory				
	Facility Comments:					
9E.4.2.5	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.					
	EVIDENCE OF COMPLIANCE	1. User training records				
		2. Competency assessment record				
		3. Letter of authorisation				
		4. List of staff trained and authorised to operate specialised equipment				
	Facility Comments:					
9E.4.2.6	Equipment is upgraded (based on evidence) from time to time so as to keep pace with advancement in operative and diagnostic techniques and technology.					
	EVIDENCE OF COMPLIANCE	1. Equipment are being replaced and upgraded to meet current standard of care and advancement in technology in a planned and systematic manner.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
STANDARD 9E.4.3		FACILITIES FOR CARDIOLOGY OUTPATIENT SERVICES Where specialist outpatient services are provided, there are adequate outpatient clinics to enable the provision of safe and effective patient care; and patient privacy and confidentiality are assured.				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9E.4.3.1	The Specialist Outpatient Services shall have the following features:					
	a) the organisation and management of the clinics are planned so as to ensure prompt attention to patients, minimal of waiting time, and avoidance of unnecessary visits by the patients;					
	b) record keeping shall be efficient;					
	c) an appointment or queuing system is used to manage patient consultations;					
	d) the clinic is easily accessible including for non-ambulant patients and is easily identified through adequate signage;					
	e) the clinic is located close to other facilities, e.g. radiology, laboratories and pharmacy.					
	f) adequate provision is made for patient comfort.					
	EVIDENCE OF COMPLIANCE	1. The Specialist Outpatient Services address (a) to (f) with evidence of but not limited to the following:				
		a) list of services available and offered to patients;				
		b) flow chart on work process;				
		c) safe keeping of medical records;				
		d) security of data in Health Information System;				
		e) clinic appointment system;				
f) monitoring of waiting time;						
g) adequate and appropriate signage;						
h) floor plan indicates accessibility to supporting services and optimisation of space;						
i) adequate patient personal use items, e.g. wheelchair, etc;						
j) adequate waiting area, rest rooms, refreshments, reading material and parking space.						

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS												
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING											
	Facility Comments:														
9E.4.3.2	Adequate numbers of rooms are provided to ensure patient privacy and confidentiality for various patient care activities including: a) consultation (only one patient in a room at any time); b) conduct of minor procedures and nursing procedures; maintain a register of procedures performed, e.g. electrocardiogram (ECG); c) performance of various tests where applicable.														
	<table><tr><td rowspan="5">EVIDENCE OF COMPLIANCE</td><td colspan="2">1. Adequate facilities for consultation and patient care activities that address (a) to (c) with evidence of but not limited to the following:</td></tr><tr><td>a) privacy of patient is ensured;</td><td></td></tr><tr><td>b) procedure room appropriately equipped;</td><td></td></tr><tr><td>c) patient monitoring device is available where required;</td><td></td></tr><tr><td>d) list of procedures done.</td><td></td></tr></table>	EVIDENCE OF COMPLIANCE	1. Adequate facilities for consultation and patient care activities that address (a) to (c) with evidence of but not limited to the following:		a) privacy of patient is ensured;		b) procedure room appropriately equipped;		c) patient monitoring device is available where required;		d) list of procedures done.				
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	Facility Comments:														

SURVEY ITEM & SELF-ASSESSMENT					
TOPIC 9E.5:		<u>SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES</u>			
STANDARD 9E.5.1		<i>The Head of Cardiology Services shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Cardiology Services. The Head of Cardiology Services shall ensure compliance to monitoring of specific performance indicators.</i>			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9E.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Cardiology Services. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.				
	EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to (f)			
		2. Records on performance improvement activities			
		3. Minutes of performance improvement meetings			
		4. Performance improvement studies			
		5. Mortality and morbidity audits with remedial actions			
		6. Records on innovation if available.			
	Facility Comments:				
9E.5.1.2	The Head of Cardiology Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement activities to appropriate individual/personnel within the respective services.				
	EVIDENCE OF COMPLIANCE	1. Minutes of meetings			
		2. Letter of assignment of responsibilities			
		3. Job description			

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS																										
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING																									
	Facility Comments:																												
9E.5.1.3	The Head of the Cardiology Safety Services shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility. Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence. <table><tr><td rowspan="9">EVIDENCE OF COMPLIANCE</td><td colspan="2">1. System for incident reporting is in place, which include:</td></tr><tr><td>a) Training of staff</td><td></td></tr><tr><td>b) Policy on incident reporting</td><td></td></tr><tr><td>c) Methodology of incident reporting</td><td></td></tr><tr><td>d) Register/records of incidents</td><td></td></tr><tr><td>2. Completed incident reports</td><td></td></tr><tr><td>3. Root Cause Analysis</td><td></td></tr><tr><td>4. Corrective and preventive action plans</td><td></td></tr><tr><td>5. Remedial measure</td><td></td></tr><tr><td>6. Minutes of meetings</td><td></td></tr><tr><td>7. Acknowledgment by Head of Service and PIC/Hospital Director</td><td></td></tr><tr><td>8. Feedback given to staff regarding incident reporting.</td><td></td></tr></table> Facility Comments:	EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:		a) Training of staff		b) Policy on incident reporting		c) Methodology of incident reporting		d) Register/records of incidents		2. Completed incident reports		3. Root Cause Analysis		4. Corrective and preventive action plans		5. Remedial measure		6. Minutes of meetings		7. Acknowledgment by Head of Service and PIC/Hospital Director		8. Feedback given to staff regarding incident reporting.				
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9E.5.1.4 CORE	The staff including cardiologist provide an appropriate peer group structure for performing the safety and performance improvement activities to accomplish clinical care evaluation. a) The cardiologists undertake clinical reviews of all risk assessments, incident reports, audits and safety and performance improvement activities: i) as a single committee for all safety and performance improvement activities; ii) in multidisciplinary committees within the service; iii) in a variety of purpose-specific committees, such as mortality and morbidity, infection control, blood transfusion, etc.																												

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	b) Whatever structure is utilised, provision is made for review and analysis of the clinical work of each individual clinical service, department, unit or function.					
	EVIDENCE OF COMPLIANCE	1. Performance improvement activities				
		2. Minutes of meetings				
		3. Relevant reports and documents, e.g. clinical audit reports, incident reports, mortality and morbidity review reports, etc.				
	Facility Comments:					
9E.5.1.5 CORE	There is tracking and trending of specific performance indicators of the following where appropriate: a) electrocardiogram taken within 10 minutes after triaging as possible Acute Coronary Syndrome patients (Target: 100%) b) mortality and morbidity review of patients with acute myocardial infarction (Target: Mortality review - 100%; Morbidity discussion based on the department's discretion) c) Thrombolytic Therapy within 30 minutes after hospital arrival in patient with acute myocardial infarction "Door to Needle" Time (Target: 90%) d) percentage of patient who received Thrombolytic Therapy (TT) in patients admitted for acute myocardial infarction (Target: 90%) e) percentage of "Normal" Diagnostic Angiogram (Target: <5%) f) major complication rate during Diagnostic Coronary Angiogram (Death, acute myocardial infarction, stroke) (Target: <1%) g) major complication rate during Percutaneous Coronary Intervention (Death, acute myocardial infarction, stroke) (Target: ≤1%) h) Percutaneous Coronary Intervention (PCI) within 90 minutes after diagnosed as acute myocardial infarction "Door to Balloon" Time (Target: 90%)					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	i) Percentage of high risk Acute Coronary Syndrome (ACS) cases undergoing Cardiac Catheterisation during the index admission (Target: $\geq 90\%$) j) Percentage of Heart Failure Mortality Rate during index hospitalisation (Target: $\leq 10\%$) k) Percentage of Heart Failure Readmission Rate at 1-month (Target: $\leq 15\%$)					
	EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored.				
		2. Records on tracking and trending analysis.				
		3. Minutes of mortality/morbidity audits meetings				
		4. Remedial measures taken where appropriate				
	Facility Comments:					
9E.5.1.6	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.					
	EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff.				
		2. Evidence of feedback via communication on results of performance improvement activities through continuing medical education/meetings.				
		3. Minutes of service/unit/committee meetings				
	Facility Comments:					
9E.5.1.7	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.					
	EVIDENCE OF COMPLIANCE	1. Documentation on performance improvement activities and performance indicators.				
		2. Policy statement on anonymity on patients and providers involved in performance improvement activities.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
SURVEY ITEM & SELF-ASSESSMENT					
<u>TOPIC 9E.6:</u>	<u>SPECIAL REQUIREMENTS</u>				
<u>STANDARD 9E.6.1</u>	<u>INVASIVE CARDIAC LABORATORY SERVICES</u>				
<u>STANDARD 9E.6.1.1</u>	<u>STAFFING, PROCESS AND SAFETY REQUIREMENTS</u> <i>The Invasive Cardiac Laboratory is constructed, equipped, operated, and maintained in a manner that enable adequate investigations and treatment of cardiac patients taking into consideration the safety of patients and staff, and in accordance to relevant regulatory requirements.</i>				
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9E.6.1.1.1 CORE	The Invasive Cardiac Laboratory Services shall be directed by a senior cardiologist and staffed by cardiologists, qualified radiographers and cardiac technicians, nursing and clerical staff. The number of staff shall commensurate with the number of investigations and treatment performed.				
	EVIDENCE OF COMPLIANCE	1. Cardiologists registered with National Specialist Register (NSR)			
		2. Letter of appointment/assignment			
		3. Staff are credentialed and certified by approved institutions.			
	Facility Comments:				
9E.6.1.1.2 CORE	Personnel working with radiation equipment shall wear appropriate monitoring devices. These devices shall be assessed periodically in an appropriate agency/laboratory. The results are reported to the relevant authority. Records are kept for constant monitoring and proactive action taken to improve the safety of the services.				
	EVIDENCE OF COMPLIANCE	1. Monthly monitoring of dosimetry by the licensed agency/laboratory approved by Atomic Energy Licensing Board (AELB), Malaysia.			

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS						
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING					
	Facility Comments:								
9E.6.1.1.3 CORE	Invasive Cardiac Laboratory Services staff and cardiologist are represented on interdepartmental committees and involved in decision making on issues related to the provision of invasive cardiac laboratory services.								
	<table><tr><td rowspan="2">EVIDENCE OF COMPLIANCE</td><td>1. Documented evidence on involvement in interdepartmental committees, e.g. letters of appointment, etc.</td><td></td></tr><tr><td>2. Minutes of meetings</td><td></td></tr></table>	EVIDENCE OF COMPLIANCE	1. Documented evidence on involvement in interdepartmental committees, e.g. letters of appointment, etc.		2. Minutes of meetings				
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	Facility Comments:								
9E.6.1.1.4 CORE	Written policies and procedures shall include the following: a) scheduling; b) investigative procedures using imaging in the Invasive Cardiac Laboratory Services; c) the administration of diagnostic agents; d) the role of technical and paramedical personnel; e) the care of patients having special needs including those who are critically ill and those needing isolation facilities; f) response time for interpretations and reporting; g) patient identification, with verification of the nature of investigation and signed informed consent documents. <i>Consent shall include disclosure if the centre is without on-site surgical backup and its potential implications;</i> h) infection control procedures, including aseptic technique, routine and terminal cleaning and procedures for infectious patients; i) patient management during recovery from anaesthesia and investigative procedure; j) priorities for using the Invasive Cardiac Laboratory Services time and space; k) the role of the Invasive Cardiac Laboratory staff in the fire and disaster plans of the Facility.								

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Policies and procedures address (a) to (k).			
		2. For centres without on-site cardiothoracic surgery, written agreements for full-time coverage and emergency transfer of patients to a facility with cardiothoracic surgery service.			
		3. All PCI cases are done only when cardiothoracic surgeon and referral centre are available to accept urgent transfer if required.			
		4. Regular testing of transfer protocols: capability for rapid response, use of intra-aortic balloon pump and intensive monitoring.			
		5. Checklists are available:-			
		a) Patient's name and Medical Record Number (MRN);			
		b) Content of patient records;			
		i) issues regarding sedation and analgesia;			
		ii) medication records;			
		iii) laboratory results;			
		iv) electrocardiogram (ECG);			
		v) assessment of bleeding risks especially for those who may receive a stent and maybe facing upcoming surgery;			
		vi) drug allergies;			
		vii) informed consent which includes disclosure if the centre is without on-site surgical backup and the potential complications.			
		c) documentation in the patients' records to include:			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		i) all potential risks and benefits to the patient, including the possible need for unplanned coronary intervention. Information should include placement of a stent and other invasive techniques used for evaluation, including the need for additional contrast use and radiation exposure.				
		6. Where it is not possible to have service providers on duty on site, e.g. after working hours provision is made to facilitate staff to be available to meet the door to balloon time of 90 minutes.				
	Facility Comments:					
9E.6.1.1.5 CORE	There is evidence of compliance with guidelines to ensure patient and staff safety, which include: a) radiation hazards; b) handling of catheters, monitoring equipment and other items; c) a manual of Technical Procedures and Routines shall be provided for radiographic and relevant staff. Equipment shall include: i) guide catheters, balloons and stents in multiple sizes; ii) covered stents; iii) temporary pacemakers; iv) pericardiocentesis sets; v) access to other diagnostic modalities such as intravascular ultrasound (IVUS) and fractional flow reserve (FFR); vi) thromboaspiration device and distal protection devices (highly recommended for centres WITHOUT on-site surgical backup) vii) rotational or other atherectomy shall not be done in centres WITHOUT on-site surgical backup.					
	EVIDENCE OF COMPLIANCE	1. Documentation of guidelines to address (a) to (c).				
		2. Verify compliance to guidelines during survey.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9E.6.1.1.6 CORE	Invasive Cardiac Laboratory Services records are adequate for clinical, medicolegal, and evaluation purposes and these include the following: a) a register of interventional procedure is maintained within the Invasive Cardiac Laboratory; b) standard anaesthetic and drug administration records are maintained, and statutory regulations relating to the control of drugs are followed; c) a record of the investigative procedure performed is written into the patients' medical records and signed by the operator. Each record contains the following: i) indication for procedure; ii) time and dose of all medications; iii) details of the procedure performed; iv) pertinent haemodynamic data obtained; v) description of angiographic findings; vi) proposed care plan; vii) personnel involved; viii) post-investigative orders; ix) reports of all investigative findings shall be signed by cardiologist.			
	EVIDENCE OF COMPLIANCE	1. Invasive Cardiac Laboratory Services records which include items listed (a) to (c).		
	Facility Comments:			
9E.6.1.1.7 CORE	Support services such as Critical Care Services (ICU/CCU) and blood bank are available and a cardiothoracic surgeon is on standby. Effective communication and relationships with these services are maintained.			
	EVIDENCE OF COMPLIANCE	1. On-site ICU/CCU and blood bank services available.		
		2. Cardiothoracic surgeon on-site or agreement with other facility providing cardiothoracic surgery support.		
	Facility Comments:			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9E.6.1.1.8 CORE	Anaesthetic services, where required, in the Invasive Cardiac Laboratory are consistent with standards in the operating suite.					
	EVIDENCE OF COMPLIANCE	1. Facilities for anaesthetic services are maintained at same standard as the operating suite.				
	Facility Comments:					
9E.6.1.1.9 CORE	Safety instruction and safety precautions are implemented according to recommendations of the International Commission of Radiation Protection (ICRP) for the protection of both patients and staff in view of the presence of hazardous equipment.					
	EVIDENCE OF COMPLIANCE	1. Verify compliance with recommendations of the International Commission of Radiation Protection (ICRP) on-site.				
	Facility Comments:					
9E.6.1.1.10 CORE	Safety precautions against radiation hazards and other health hazards shall be developed and supervised by designated personnel of the Invasive Cardiac Laboratory Services. Such measures shall include instructions, signage, policies and procedures against the following hazards: a) electrical and mechanical hazards; b) fire and explosion; c) radiation hazard.					
	EVIDENCE OF COMPLIANCE	1. Documentation on safety precautions is signed by designated personnel.				
		2. Compliance with safety precautions against radiation hazards and other hazards are monitored and documented.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9E.6.1.1.11 CORE	Rooms and equipment shall be assessed for safety at yearly intervals by independent radiation experts (Class H license holders certified by Engineering Services Division Ministry of Health). Records on such assessment are kept.					
	EVIDENCE OF COMPLIANCE	1. Valid licence is available.				
		2. Records on yearly inspection of records on rooms and equipment.				
	Facility Comments:					
9E.6.1.1.12 CORE	Multilingual signs warning women of childbearing age about radiation dangers shall be prominently displayed.					
	EVIDENCE OF COMPLIANCE	1. Availability of multilingual signs warning women of childbearing age about radiation dangers				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT				
STANDARD 9E.6.1.2	FACILITIES FOR INVASIVE CARDIAC LABORATORY <i>There are appropriate and adequate physical facilities and equipment for the safe and efficient functioning of the Invasive Cardiac Laboratory Services.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9E.6.1.2.1 CORE	The design of the Invasive Cardiac Laboratory Services supports efficient systems for the management of invasive cardiac procedures. This includes:			
	a) suitable area in reception of patients awaiting procedure; b) recovery area; c) adequate space for patient movement within the laboratory; d) adequate storage space for equipment, surgical supplies, linen, housekeeping equipment and pharmaceutical supplies including dangerous drugs; e) separate areas for collection and separate area for disposal of used equipment and waste; f) staff change and scrub rooms.			
	EVIDENCE OF COMPLIANCE 1. Services as approved in the current Facility's licence.			
	2. Design of the Invasive Cardiac Laboratory Services include (a) to (f).			
	3. Space area complies with requirements from Radiation Safety Section, Engineering Services Division, Ministry of Health Malaysia.			
	Facility Comments:			
9E.6.1.2.2 CORE	The design of the Invasive Cardiac Laboratory Services complies with fire safety requirements which include: a) fire detection, alarm and suppression systems; firefighting equipment and appropriate sign posting; b) adequate means of egress from the laboratory in the event of fire; c) ready access for routing emergency patients; d) free movement of patient trolleys throughout the laboratory with minimum cross traffic.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Design of the Invasive Cardiac Laboratory Services complies with fire safety requirements which include (a) to (d).				
		2. Complies with requirements from Radiation Safety Section, Engineering Services Division, Ministry of Health Malaysia.				
	Facility Comments:					
9F.6.1.2.3 CORE	Other systems include: a) adequate numbers of general power outlets distributed according to needs of each area; b) suitable lighting and at least one procedure light with uninterrupted power supply (UPS); c) environmental control of temperature and humidity within safe limits especially in procedure rooms; d) adequate provision for emergency electrical supply and suction of an appropriate nature complying with current Malaysian Standards; e) adequate numbers of various medical gas outlets and wall suction outlets and gadgets complying with current Malaysian Standards; f) fluoroscopy units shall have image intensifiers.					
EVIDENCE OF COMPLIANCE	1. Invasive Cardiac Laboratory equipped with features listed (a) to (f).					
	2. Compliance with requirements from Radiation Safety Section, Engineering Services Division, Ministry of Health Malaysia.					
Facility Comments:						
9E.6.1.2.4 CORE	Safety features include: a) compliance with electrical standards for cardiac-protected or body-protected electrical areas, where required; b) electrical equipment complying with Malaysian Standards/Standards and Industrial Research Institute of Malaysia (SIRIM); c) appropriate shielding and protective clothing are provided in the presence of biohazards or radiographic equipment;					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	d) schedule for regular maintenance and monitoring of mechanical and electrical facilities and biomedical equipment, and system of repair and replacement.					
	Notes/Explanations Body protection means basically that every power point needs to be protected by 10 milli amp R.C.D's or a Safety Switch which is the same as in most houses but more sensitive to Earth Leakage Currents.					
	EVIDENCE OF COMPLIANCE				1. Safety features as stated in (a) to (d) are addressed in Invasive Cardiac Laboratory	
					2. Safety features complies with requirement from Radiation Safety Section, Engineering Services Division, Ministry of Health Malaysia.	
	Facility Comments:					
9E.6.1.2.5 CORE	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.					
	EVIDENCE OF COMPLIANCE				1. Testing, commissioning and calibration records (certificates or stickers)	
					2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as evidence of compliance to the relevant standards and Acts.	
	Facility Comments:					
9E.6.1.2.6 CORE	There is evidence that the facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.					
	Notes/Explanations a) Scheduled planned preventive maintenance applies to electric services, medical gases, air conditioning, major equipment, emergency and resuscitation equipment. b) Emergency biomedical equipment is thoroughly tested as a routine, e.g. defibrillator is discharged and output checked every day or after each use and the result is recorded.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Planned Preventive Maintenance records, such as schedule, stickers, etc.				
		2. Planned Replacement Programme where applicable				
		3. Complaint records				
		4. Asset inventory				
	Facility Comments:					
9E.6.1.2.7 CORE	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.					
	EVIDENCE OF COMPLIANCE	1. User training records				
		2. Competency assessment record				
		3. Letter of authorisation				
		4. List of staff trained and authorised to operate specialised equipment				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
STANDARD 9E.6.2	<u>NON-INVASIVE CARDIAC LABORATORY SERVICES</u>					
STANDARD 9E.6.2.1	<u>STAFFING, PROCESS AND SAFETY REQUIREMENTS</u> <i>The Non-Invasive Cardiac Laboratory is constructed, equipped, operated, and maintained in a manner that enable adequate investigations of cardiac patients taking into consideration the safety of patients and staff, and in accordance to relevant regulatory requirements. Investigations requiring the use of radioactive substances shall not be carried out in this laboratory but in an area specially equipped to handle such substances to ensure safety of patients and staff.</i>					
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
9E.6.2.1.1 CORE	The Non-Invasive Cardiac Laboratory Services shall be under the appointed Head of Cardiology Services, and staffed by cardiologists, qualified technical, nursing and clerical staff. The number of staff shall commensurate with the number of investigations and treatment performed.					
	EVIDENCE OF COMPLIANCE	1. Cardiologists registered with National Specialist Register (NSR)				
		2. Letter of appointment/assignment				
		3. Staff are credentialed and certified by approved institutions.				
	Facility Comments:					
9E.6.2.1.2 CORE	Personnel working in non-invasive cardiac laboratory shall be assessed periodically with regards to competency in the operation of the equipment. In the operation of certain specific equipment, e.g. echocardiography, the personnel shall be credentialed and privileged to operate the machine.					
	EVIDENCE OF COMPLIANCE	1. Credentialing and privileging process in place.				
		2. List of personnel privileged and for specific procedures.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS						
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING					
9E.6.2.1.3 CORE	The results of tests shall be reported and signed by the cardiologist/physician with adequate training.								
	<table><tr><td>EVIDENCE OF COMPLIANCE</td><td>1. Results of tests are reported and signed by the cardiologist/physician with adequate training.</td><td></td></tr></table>				EVIDENCE OF COMPLIANCE	1. Results of tests are reported and signed by the cardiologist/physician with adequate training.			
	EVIDENCE OF COMPLIANCE				1. Results of tests are reported and signed by the cardiologist/physician with adequate training.				
	Facility Comments:								
9E.6.2.1.4 CORE	Non-Invasive Cardiac Laboratory Services staff are represented on interdepartmental committees and involved in decision making on issues related to the provision of non-invasive cardiac laboratory services.								
	<table><tr><td rowspan="2">EVIDENCE OF COMPLIANCE</td><td>1. Documented evidence on involvement interdepartmental committees, e.g. letters of appointment, etc.</td><td></td></tr><tr><td>2. Minutes of meetings</td><td></td></tr></table>				EVIDENCE OF COMPLIANCE	1. Documented evidence on involvement interdepartmental committees, e.g. letters of appointment, etc.		2. Minutes of meetings	
	EVIDENCE OF COMPLIANCE					1. Documented evidence on involvement interdepartmental committees, e.g. letters of appointment, etc.			
					2. Minutes of meetings				
	Facility Comments:								
9E.6.2.1.5 CORE	Written policies and procedures shall include the following: a) scheduling; b) the administration of drugs; c) the role of technical and paramedical personnel; d) the care of patients having special needs including those who are critically ill and those needing isolation facilities; e) response time for interpretations and reporting; f) patient identification, with verification of the nature of investigation and signed informed consent documents; g) infection control procedures, including aseptic technique, routine and terminal cleaning and procedures for infectious patients; h) patient management during recovery from investigative procedures; i) priorities for using the Non-Invasive Cardiac Laboratory Services time and space; j) the role of the Non-Invasive Cardiac Laboratory staff in the fire and disaster plans of the Facility.								

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Policies and procedures address items (a) to (j).				
	Facility Comments:					
9E.6.2.1.6 CORE	A manual of Technical Procedures and Routines shall be provided for relevant staff which include the following: a) electrocardiography (ECG); b) stress test; c) echocardiogram; d) HOLTER monitoring.					
	EVIDENCE OF COMPLIANCE	1. A manual of Technical Procedures and Routines which include investigations listed (a) to (d) are available.				
	Facility Comments:					
9E.6.2.1.7 CORE	There is evidence of compliance with guidelines to ensure patient and staff safety in the handling of, monitoring and investigative equipment and other items.					
	EVIDENCE OF COMPLIANCE	1. Observation on compliance with guidelines during survey				
	Facility Comments:					
9E.6.2.1.8 CORE	Non-Invasive Cardiac Laboratory Services records are adequate for clinical, medicolegal, and evaluation purposes and these include the following:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	a) standard drug administration records are maintained, and statutory regulations relating to the control of drugs are followed; b) a record of the investigative procedure performed is written into the patients' medical records. Each record contains the indication for procedure, time and dose of all medications, details of the procedure performed, description of findings, proposed care plan, personnel involved, and post-investigative orders signed by the cardiologist/physician requesting the investigation.				
	EVIDENCE OF COMPLIANCE	1. Non-Invasive Cardiac Laboratory Services records include items listed (a) to (b).			
	Facility Comments:				
9E.6.2.1.9 CORE	Support services such as Critical Care Services (ICU/CCU) are available/accessible and where appropriate a cardiologist is on standby. Effective communication and relationships with these services are maintained.				
	EVIDENCE OF COMPLIANCE	1. On-site ICU/CCU services available.			
		2. Cardiothoracic surgeon on-site or agreement with other facility providing cardiothoracic surgery support.			
	Facility Comments:				
9E.6.2.1.10 CORE	Safety instruction and safety precautions are implemented for the protection of both patients and staff.				
	EVIDENCE OF COMPLIANCE	1. Safety instructions and safety precautions are available.			
		2. Observation on implementation of safety precautions during survey			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT					
STANDARD 9E.6.2.2	<u>FACILITIES FOR NON-INVASIVE CARDIAC LABORATORY</u> <i>There are appropriate and adequate physical facilities and equipment for the safe and efficient functioning of the Non-Invasive Cardiac Laboratory.</i>				
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9E.6.2.2.1 CORE	The design of the Non-Invasive Cardiac Laboratory Services provides adequate space: a) for reception of patient awaiting procedures; b) adequate space and rooms for different investigative procedures to ensure privacy; c) adequate storage space for equipment, surgical supplies, linen, housekeeping equipment and pharmaceutical supplies; d) area for resuscitation.				
	EVIDENCE OF COMPLIANCE	1. Services as approved in the current Facility's licence.			
		2. Design of the Non-Invasive Cardiac Laboratory Services includes facilities listed (a) to (d).			
	Facility Comments:				
9E.6.2.2.2 CORE	The design of the Non-Invasive Cardiac Laboratory Services complies with fire safety requirements which include: a) fire detection, alarm and suppression systems; firefighting equipment and appropriate sign posting; b) adequate means of egress from the laboratory in the event of fire; c) ready access for routing emergency patients; d) free movement of patients throughout the laboratory with minimum cross traffic.				
	EVIDENCE OF COMPLIANCE	1. Design of the Invasive Cardiac Laboratory Services complies with fire safety requirements which include items listed (a) to (d).			
		Facility Comments:			

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS							
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING						
9E.6.2.2.3 CORE	Other systems include: a) adequate numbers of general power outlets distributed according to needs of each area; b) suitable lighting; c) environmental control of temperature and humidity within safe limits especially in procedure rooms; d) adequate numbers of oxygen outlets and wall suction outlets, emergency electric supply in rooms, e.g. where stress tests are performed; e) resuscitation trolley shall be readily available. <table><tr><td>EVIDENCE OF COMPLIANCE</td><td>1. Non-Invasive Cardiac Laboratory equipped with features listed (a) to (e).</td><td></td></tr></table> Facility Comments:	EVIDENCE OF COMPLIANCE	1. Non-Invasive Cardiac Laboratory equipped with features listed (a) to (e).							
EVIDENCE OF COMPLIANCE	1. Non-Invasive Cardiac Laboratory equipped with features listed (a) to (e).									
9E.6.2.2.4 CORE	Safety features include: a) electrical equipment complying with Malaysian Standards; b) schedule for regular maintenance and monitoring of mechanical and electrical facilities and biomedical equipment, and system of repair and replacement. <table><tr><td>EVIDENCE OF COMPLIANCE</td><td>1. Safety features as listed (a) to (b) are addressed in the Non-Invasive Cardiac Laboratory</td><td></td></tr></table> Facility Comments:	EVIDENCE OF COMPLIANCE	1. Safety features as listed (a) to (b) are addressed in the Non-Invasive Cardiac Laboratory							
EVIDENCE OF COMPLIANCE	1. Safety features as listed (a) to (b) are addressed in the Non-Invasive Cardiac Laboratory									
9E.6.2.2.5 CORE	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements. <table><tr><td>EVIDENCE OF COMPLIANCE</td><td>1. Testing, commissioning and calibration records (certificates or stickers)</td><td></td></tr><tr><td></td><td>2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as evidence of compliance to the relevant standards and Acts.</td><td></td></tr></table> Facility Comments:	EVIDENCE OF COMPLIANCE	1. Testing, commissioning and calibration records (certificates or stickers)			2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as evidence of compliance to the relevant standards and Acts.				
EVIDENCE OF COMPLIANCE	1. Testing, commissioning and calibration records (certificates or stickers)									
	2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as evidence of compliance to the relevant standards and Acts.									

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9E.6.2.2.6 CORE	There is evidence that the facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.				
	Notes/Explanations				
	a) Scheduled planned preventive maintenance applies to electric services, medical gases, air conditioning, major equipment, emergency and resuscitation equipment.				
	b) Emergency biomedical equipment is thoroughly tested as a routine, e.g. defibrillator is discharged and output checked every day or after each use and the result is recorded.				
	EVIDENCE OF COMPLIANCE	1. Planned Preventive Maintenance records, such as schedule, stickers, etc.			
		2. Planned Replacement Programme where applicable			
		3. Complaint records			
4. Asset inventory					
Facility Comments:					
9E.6.2.2.7 CORE	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.				
	EVIDENCE OF COMPLIANCE	1. User training records			
		2. Competency assessment record			
		3. Letter of authorisation			
		4. List of staff trained and authorised to operate specialised equipment			
	Facility Comments:				

SERVICE SUMMARY	
SURVEYOR SUMMARY:	
OVERALL RATING:	
OVERALL RISK:	

SURVEY ITEM & SELF-ASSESSMENT				
SERVICE STANDARD 9F : CLINICAL SERVICES - ONCOLOGY SERVICES				
	PREAMBLE <i>The Oncology Services shall be organised, directed and coordinated with other services in the Facility to provide a high standard of inpatient and outpatient care to the community and cover the following but not limited to:-</i> a) <i>appropriateness of clinical care</i> b) <i>unwarranted variation in care that is not explained by the clinical circumstances or personal choices of the oncologists in:-</i> i) <i>overuse of treatments or procedures that do not help patients get better;</i> ii) <i>underuse of care;</i> iii) <i>misuse (or errors) of doing something incorrectly and harming patients.</i>			
TOPIC 9F.1: STANDARD 9F.1.1	ORGANISATION AND MANAGEMENT <i>The Oncology Services shall be organised, directed and coordinated with other services in the Facility to provide a high standard of inpatient and outpatient care to the community in a safe, efficient, effective, evidence based and caring manner with due regard for the needs, dignity and privacy of patients and confidentiality of their personal information. The Oncology Services shall be easily accessible, patient focused and continuity of care assured.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9F.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Oncology Services are clearly documented and measurable that indicates safety, quality and patient centred care. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required and communicated to all staff.			
	EVIDENCE OF COMPLIANCE 1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.			
	2. Goals and objectives of the Oncology Services in line with the Facility statements are available, endorsed and dated.			
	3. Evidence of planned reviews of the above statements.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc) 5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.				
		Facility Comments:				
9F.1.1.2 CORE		There is an organisation chart which: a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head of the Oncology Services, consultants, medical practitioners and staff of the Oncology Services. b) is accessible to all staff and clients; c) is revised when there is a major change in any of the following: i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns.				
	EVIDENCE OF COMPLIANCE	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head of the Oncology Services, consultants, medical practitioners and staff of the Oncology Services. 2. Organisation chart of the service is endorsed, dated and accessible. 3. The organisation chart is revised when there is a major change in any of the items (c)(i) to (iv).				
		Facility Comments:				
9F.1.1.3		The Governing Body shall ensure that the Oncology Services are organised as to: a) facilitate the provision of oncology services to patients in the Facility in a safe, efficient, effective, and caring manner and with due regard for the needs, dignity and privacy of patients and confidentiality of their personal information; b) assure continuity of care; c) address the professional needs of the oncologists; d) ensure that the oncologists are involved in the formulation of policies and procedures concerning patient care appropriate to the scope of services of the Facility.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Departmental/Service operational policies that address items (a) to (d).				
		2. Medical Staff By-Laws				
		3. Evidence of involvement of oncologists in the formulation of policies and procedures concerning patient care.				
		4. Involvement of Head of the Service in the Medical and Dental Advisory Committee/Medical Advisory Committee and ward meetings.				
		5. Minutes of meetings				
		6. Proper and adequate equipment according to current standards.				
	Facility Comments:					
9F.1.1.4	There is a mechanism to ensure effective interaction between the Oncology Services and the Governing Body and Management in all clinical aspects of healthcare and other relevant matters in the Facility. This mechanism is defined in the policies of the Governing Body and is accomplished through: a) the appointment/assignment of an oncologist as the Head of Oncology Services delineating his/her authority, responsibilities and accountabilities in a written document according to the relevant Acts, to manage and control the Oncology Services; b) Medical and Dental Advisory Committee to advise the Governing Body on issues related to clinical governance, i.e. planning, coordinating, implementation, control and to improve activities relating to Oncology Services.					
EVIDENCE OF COMPLIANCE	1. Letter of appointment/assignment and delineation of duties and responsibilities of the Head of the Service.					
	2. Letter of appointment and Terms of Reference as member of the Medical and Dental Advisory Committee/Medical Advisory Committee.					
Facility Comments:						
9F.1.1.5 CORE	The Head of Oncology Services has: a) representation of the Service in committees and subcommittees where relevant;					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	b) representation of the Service in clinical staff liaison meetings; c) involvement and provide regular input to the Senior Management Team.				
	EVIDENCE OF COMPLIANCE	1. Letter of representation of the Head of Service in committees and subcommittees where relevant, e.g. Blood Transfusion Committee, Medical Records Committee, Hospital Infection and Antibiotic Control Committee, etc.			
		2. Minutes of meetings of committees			
		3. Minutes of meeting of Senior Management Team.			
	Facility Comments:				
9F.1.1.6	The assessment, planning, direction, evaluation and continuity of clinical care are the responsibility of oncologists managing individual patients, thus ensuring clinical independence.				
	EVIDENCE OF COMPLIANCE	1. Medical Staff By-Laws; clause indicate clinical care responsibility of oncologists.			
		2. Documented evidence of clinical notes in the patient's medical record; e.g. documentation on assessment, planning, direction, evaluation and continuity of clinical care, valid name stamp of medical practitioner.			
	Facility Comments:				
9F.1.1.7	The Head of Oncology Services shall be involved for the following aspects of management of the services: a) the preparation of budget and ensuring that expenditure remains within the budget allocated; b) human resource management and development; c) development of policies and procedures and ensuring their compliance; d) facility and equipment management; e) safety and performance improvement activities and risk management.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Evidence of items (a) to (e) in the minutes of meetings of Oncology Services indicates the involvement of Head of Service.				
		2. Request for allocation of budget and staffing				
		3. Endorsement of policies and procedures				
		4. Implementation of performance improvement activities				
	Facility Comments:					
9F.1.1.8	Regular staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Oncology Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.					
	EVIDENCE OF COMPLIANCE	1. Minutes are accessible, disseminated and acknowledged by the staff.				
		2. Attendance list of members with adequate representatives of the service.				
		3. Frequency of meetings as scheduled.				
		4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).				
	Facility Comments:					
9F.1.1.9	Where there are medical practitioners in training, there is evidence that: a) their responsibilities for patient care are documented; b) their training needs are identified; c) appropriate supervision and training are given to these medical practitioners.					
	EVIDENCE OF COMPLIANCE	1. Log books				
		2. Assessment reports				
		3. Training timetable, continuing medical education and attendances list.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9F.1.1.10	Appropriate statistics and records shall be maintained in relation to the provision of Oncology Services and used for managing the services and patient care purposes.					
	EVIDENCE OF COMPLIANCE	1. Records are available but not limited to the following:				
		a) workload/census for inpatients and outpatients;				
		b) annual report;				
		c) accident/incident reports;				
		d) staffing number and staff profile;				
		e) staff training records;				
		f) data on performance improvement activities, including performance indicators.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT				
TOPIC 9F.2	<u>HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT</u>			
STANDARD 9F.2.1	<u>CREDENTIALING AND PRIVILEGING</u> <i>The Oncology Services shall be directed by a qualified and competent oncologist, and staffed by suitably qualified and competent clinical staff to achieve the goals and objectives of the Oncology Services.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9F.2.1.1 CORE	There is documented evidence of appropriate training and competency for the granting of clinical privileging. The criteria for determining privileges are specified and documented. There is a structured process to ensure the stated criteria are uniformly applied to all applicants. These include: a) the criteria are designed to assure that patients will receive safe and quality care; b) the criteria for individual privileging for specific procedures are documented in detail, e.g. competency records/log books, application from the individual practitioner, recommendations from peer/referee and minutes of meeting; c) competency for each performance is dated, verified and signed by the supervisors; d) the period of time for which the privileges are to be granted is specified; e) current registration with the local professional registration bodies, e.g. Malaysian Medical Council, National Specialist Register (NSR); f) peer recommendations are taken into account when privileges are being considered; g) the recommendations of the relevant department and/or major professional services for privileges to be granted are taken into consideration.			
	1. Documented policies and procedures are established to govern the credentialing and privileging processes which include items (a) to (g).			
	2. Compliance with policy and criteria for credentialing and privileging			
	3. Competency records/log books			
	4. Recommendations from peer/referee			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS				
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING			
		5. Annual Practising Certificate (APC), National Specialist Register (NSR) certificate and privileging certificate.							
		6. Availability of the list of procedures requiring credentialing and privileging.							
		7. Availability of list of procedures to include core procedures specific to the disciplines performed by medical officers.							
		8. Only radiation and clinical oncologists can prescribe radiotherapy.							
		9. Only clinical and medical oncologists can prescribe chemotherapy.							
		10. Pharmacist Certification for "Cancer Chemotherapy Preparation" training programme							
		11. Qualified and Privileged Medical Physicist							
		12. Qualified and Privileged nurses and radiographers for Oncology Services							
	Facility Comments:								
9F.2.1.2 CORE	Documented evidence of privileges conferred by the Governing Body is available and accessible to relevant staff at point of care.								
	EVIDENCE OF COMPLIANCE	1. Formal letter of assignment or certificate of privileging with stipulated timeline are issued and reviewed accordingly.							
		2. Updated list of staff with privileges conferred is made accessible at point of care.							
	Facility Comments:								
9F.2.1.3	Clinical staff performs within the privileges conferred.								
	EVIDENCE OF COMPLIANCE	1. Verification of procedures performed by individuals at point of care within the awarded privileging rights with evidence of:							
		a) list of procedures privileged;							
		b) operating list;							

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		c) operating notes/clinical notes.				
	Facility Comments:					
9F.2.1.4	There are written and dated specific job descriptions for all categories of clinical staff that include: a) qualifications, training, experience and certification required for the position; b) lines of authority; c) accountability, functions, and responsibilities; d) reviewed when required and when there is a major change in any of the following: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations. e) administrative and clinical functions.					
	EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e).				
		2. Job description includes specialisation skills				
		3. Relevant privileges granted where applicable				
		4. The job description is acknowledged by the staff and signed by the Head of Service and dated.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT					
STANDARD 9F.2.2	STAFF TRAINING, EDUCATION, APPRAISAL AND RESEARCH <i>The Facility and all staff shall demonstrate an ongoing commitment to continuing medical education.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9F.2.2.1	There are continuing education activities for staff including oncologists to pursue professional interests and to prepare for current and future changes in practice.				
	EVIDENCE OF COMPLIANCE	1. Training calendar includes in-house/external courses/workshop/conferences			
		2. Contents of training programme			
		3. Training records on continuing education activities are kept and maintained for each staff including training in life support.			
		4. Certificate of attendance/degree/post basic training			
	Facility Comments:				
9F.2.2.2	The educational needs of staff and the Facility, as evidenced by the results of medical-care evaluation such as incident reports, performance improvement studies and complaints, are taken into consideration when the content and structure of educational activities are planned.				
	EVIDENCE OF COMPLIANCE	1. Evidence of inclusion of results of audit activities, e.g. mortality and morbidity reviews, incident reporting, etc in educational activities.			
		2. Evidence of improvement made from corrective or preventive measures from incident reports.			
	Facility Comments:				
9F.2.2.3	In a Facility where undergraduate medical, nursing and allied health training programmes are conducted, the Facility shall ensure that there are sufficient skilled trained staff to provide clinical supervision of students.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Sufficient skilled trained staff to provide clinical supervision as per terms of Memorandum of Understanding.				
	Facility Comments:					
9F.2.2.4	There is evidence of an initial and on-going Facility approved training programme for staff to maintain competency in their current positions as the demand of the positions evolve.					
	EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and gaps identified.				
		2. A staff development plan based on training needs assessment is available.				
		3. Training schedule/calendar is in place.				
		4. Training module, e.g. safe handling of cytotoxic drugs, spill or leak management etc.				
	Facility Comments:					
9F.2.2.5	Staff including oncologists receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.					
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff including oncologists is completed upon probationary period and as an annual exercise.				
	Facility Comments:					
9F.2.2.6	Where appropriate the Facility shall endeavour to undertake clinical research using available resources.					
	EVIDENCE OF COMPLIANCE	1. Documented evidence of research activities e.g. protocol, policies, consent etc.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
SURVEY ITEM & SELF-ASSESSMENT				
STANDARD 9F.2.3	<u>STAFFING LEVEL AND STAFF COMPETENCY</u> <i>The Head and staff of the Oncology Services including medical practitioners are individuals qualified by education, training and experience commensurate with the requirements of the various positions and relevant laws.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9F.2.3.1	Deployment of all service providers for the Oncology Services takes the following factors into consideration: a) the number of persons deployed is proportional to the number of patients being cared for as in regulatory requirements and for the intensity of care provided; b) the categories of service providers based on qualifications and experience providing care reflect the complexity of clinical problems being managed; c) staffing needs shall take into consideration absences due to leave or illness; double shift duties by clinical staff shall be documented and monitored; d) adequate staffing levels of appropriate competency shall be maintained throughout the hours the services are in operation. Where services need to be provided on a 24-hour basis, staffing level reflects the intensity of activities during each shift; e) where it is not possible to have service providers on duty on site, e.g. after working hours, provision is made for relevant medical practitioners to be available on call.			
	EVIDENCE OF COMPLIANCE 1. Documentation and planning on deployment of staff that includes but not limited to items (a) to (e) with evidence of: a) deployment based on staff to patient ratio, bed occupancy rate and complexity of cases; b) special skills/training of staff; post basic trained nurses available in every shift; c) contingency plan during acute shortage; d) duty roster.			
	Facility Comments:			

SURVEY ITEM & SELF-ASSESSMENT											
STANDARD 9F.2.4	STAFF ORIENTATION <i>A structured orientation programme introduces new staff to their services, operational policies and relevant aspects of the Facility to prepare them for their roles and responsibilities.</i>										
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS								
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING							
9F.2.4.1	There is a structured orientation programme for all newly appointed staff to the Oncology Services including oncologists and for those new to specific areas that include the following: a) explanation of the goals, objectives, policies and procedures of the Facility and those of the Oncology Services; b) lines of authority and areas of responsibility; c) explanation of particular duties and functions; d) explanation of the methods of assigning clinical care and the standards of clinical practice; e) handover communication; f) processes for resolving practice dilemmas; g) information about safety procedures; h) training in basic/advanced life support techniques; i) methods of obtaining appropriate resource materials; j) staff appraisal procedures for the Oncology Services; k) education on Patient and Family Rights; l) education on MSQH Standards requirements.										
	<table><tr><td rowspan="3">EVIDENCE OF COMPLIANCE</td><td>1. Policy requiring all new staff to attend a structured orientation programme</td><td></td></tr><tr><td>2. There is Oncology Services orientation programme with relevant topics not limited to topics covered from (a) to (l).</td><td></td></tr><tr><td>3. Attendance list</td><td></td></tr></table>	EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme		2. There is Oncology Services orientation programme with relevant topics not limited to topics covered from (a) to (l).		3. Attendance list				
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	3. Attendance list										
	Facility Comments:										

SURVEY ITEM & SELF-ASSESSMENT				
TOPIC 9F.3:	<u>POLICIES AND PROCEDURES</u>			
STANDARD 9F.3.1	<u>DEVELOPMENT, DERIVATION AND DOCUMENTATION</u> <i>There are written and dated policies and procedures for all activities of the Oncology Services. These policies and procedures reflect current standards of medical practice, relevant regulations, statutory requirements, and the purposes of the services. These policies and procedures, terms of reference, by-laws, rules or regulations, state how the clinical staff including medical practitioners regulate themselves and provide patient care. There shall be a list of procedures requiring informed consent specific to oncology. Possible risks and complications arising from procedures shall be documented either in specific consent forms or in patient's records.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9F.3.1.1 CORE	There are written policies and procedures for the Oncology Services which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated.			
	There is a mechanism for and evidence of a periodic review at least once in every three years.			
	EVIDENCE OF COMPLIANCE			
	1. Documented policies and procedures for the service.			
	2. Policies and procedures are consistent with regulatory requirements and current standard practices.			
	3. Evidence of periodic review of policies and procedures.			
9F.3.1.2	4. The policies and procedures are endorsed and dated.			
	Facility Comments:			
9F.3.1.2	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved. Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.				
		2. Minutes of meeting with evidence of cross reference with other departments				
		3. Cross departmental policies				
	Facility Comments:					
9F.3.1.3 CORE	The policy and procedure documentation shall cover at least the following topics and any others required by law: a) description of the organisational structure of the Oncology Services; b) clinical practice guidelines; c) clinical documentation includes pain as the 5 th vital sign where appropriate; d) handover communication; e) treatment prescription (includes drug and radiation), dispensing and administration. All cancer chemotherapy are ordered on approved format; f) blood transfusion where applicable; g) continuing of care including regular review of patient, review of investigation results, discharge (planned or At Own Risk), referrals and escort as necessary; h) pain management; i) management of patients under police custody/prisoner; j) management of cases with an infectious disease including notification of notifiable diseases; k) the responsibilities of all staff in relation to internal and external disasters are documented, and known to the staff (contingency plan); l) incident reports shall be compiled, investigated, discussed, recorded and action plans implemented; m) end of life care; n) management of a death.					
EVIDENCE OF COMPLIANCE	1. Documented policies and procedures that address but not limited to items (a) to (n).					
	2. Checklist for patient chart documentation:					
	a) history and physical examination;					
	b) past medical history;					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		c) review of systems and review of imaging studies and laboratory data; d) histopathology diagnosis; e) recommendations for treatment. 3. Treatment prescriptions should include planning and checklist for chemotherapy, radiation therapy and brachytherapy where applicable.				
		Facility Comments:				
9F.3.1.4		Current policies and procedures are communicated to all staff.				
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings 2. Circulation list and acknowledgement				
		Facility Comments:				
9F.3.1.5 CORE		There is evidence of compliance with policies and procedures.				
	EVIDENCE OF COMPLIANCE	1. Compliance with policies and procedures through: a) staff interview on practices; b) verify with observation on practices; c) results of audit on practices; d) practices in line with established policies and procedures.				
		Facility Comments:				
9F.3.1.6		Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.				
	EVIDENCE OF COMPLIANCE	1. Copies of relevant policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	Facility Comments:				
9F.3.1.7	The services shall operate on a 24-hour basis providing a level of care appropriate to the activities of the patients in the Facility.				
	EVIDENCE OF COMPLIANCE	1. Operational policy on 24-hour services			
		2. Staffing level reflects good mix of experienced staff and the intensity of activities during each shift.			
		3. On-call roster is dated and authorised.			
		4. Observation for compliance with policy			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 9F.4: FACILITIES AND EQUIPMENT						
STANDARD 9F.4.1 <i>The Head of Oncology Services shall ensure adequate facilities and equipment that are safe and appropriate are available for the staff to function effectively and to meet the goals and objectives of the services.</i>						
CRITERIA FOR COMPLIANCE:				SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9F.4.1.1	There are adequate and appropriate facilities and equipment with proper utilisation of space to enable staff to carry out their professional, teaching and administrative functions.					
	EVIDENCE OF COMPLIANCE	1. Adequate and proper utilisation of space.				
		2. Appropriate type of equipment to match the complexity of services.				
		3. Adequate facilities and equipment at each patient care area for safe care. (e.g. defibrillators, emergency cart, hand washing facilities, etc)				
		4. Easy access and clear exit routes				
		5. Absence of overcrowding				
	Facility Comments:					
9F.4.1.2	Existing facilities shall take cognisance of the safety of staff and patients.					
	EVIDENCE OF COMPLIANCE	1. Design and layout of the unit, e.g. wards, treatment rooms, dirty and clean utility rooms, access, lighting, signage, etc address the safety aspects of patients and staff.				
		2. Adequate equipment and supplies for Oncology Services, e.g. emergency trolley, functioning patient call bell, etc.				
		3. Equipment should have scheduled planned preventive maintenance (PPM).				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9F.4.1.3	Suitable and adequate forms of communication and inter-communication systems and equipment are provided to enable clinical staff to communicate among themselves and with the other members of the healthcare team.				
	EVIDENCE OF COMPLIANCE	1. Appropriate telecommunication modalities available for daily operation and during emergencies.			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT										
STANDARD 9F.4.2	<i>FACILITIES AND EQUIPMENT FOR PATIENT CARE</i> <i>Adequate facilities and equipment shall be available to provide safe and effective patient care.</i>									
	CRITERIA FOR COMPLIANCE:				SELF RATING	SURVEYOR FINDINGS				
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING			
9F.4.2.1	Facilities are suitably located to facilitate easy access and to provide an atmosphere of user, environmental and 'disabled' friendly.									
	EVIDENCE OF COMPLIANCE	1. Floor plan indicates accessibility and patient and user friendly.								
		2. Feedback from patient satisfaction survey								
		3. Incident reporting relating to facilities if any.								
	Facility Comments:									
9F.4.2.2	Equipment, both for emergency and non-emergency usage, shall be appropriate to the level of care.									
	EVIDENCE OF COMPLIANCE	1. Availability of emergency and non-emergency equipment appropriate to level of care, such as defibrillator, emergency trolley, suction machine, electrocardiogram (ECG) machine, infusion or syringe pump, vital sign monitor, etc.								
		2. Scheduled checking of items in emergency trolley								
	Facility Comments:									
9F.4.2.3	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.									
	EVIDENCE OF COMPLIANCE	1. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), Agency Nuclear Malaysia, etc as evidence of compliance to the relevant standards and Acts.								
		2. Testing, commissioning and calibration records (certificates or stickers)								

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	3. Biological Safety Cabinet (BSC) for preparation of chemotherapy drugs comply with Class II Type B or better, externally-vented BSC which must have airflow monitoring devices and be certified every year.				
	4. Sterile disposable equipment is used for all cancer chemotherapy drugs, luer-lock devices etc.				
	Facility Comments:				
9F.4.2.4 CORE	There is evidence that the facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.				
	EVIDENCE OF COMPLIANCE	1. Planned Preventive Maintenance records, such as schedule, stickers, etc.			
		2. Planned Replacement Programme (where applicable)			
		3. Complaint records			
		4. Asset inventory			
	Facility Comments:				
9F.4.2.5	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.				
	EVIDENCE OF COMPLIANCE	1. User training records			
		2. Competency assessment record			
		3. Letter of authorisation			
		4. List of staff trained and authorised to operate specialised equipment			
	Facility Comments:				
9F.4.2.6	Equipment is upgraded (based on evidence) from time to time so as to keep pace with advancement in operative and diagnostic techniques and technology.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Equipment are being replaced and upgraded to meet current standard of care and advancement in technology in a planned and systematic manner.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT																												
STANDARD 9F.4.3	<u>FACILITIES FOR ONCOLOGY OUTPATIENT SERVICES</u> <i>Where specialist outpatient services are provided, there are adequate outpatient clinics to enable the provision of safe and effective patient care; and patient privacy and confidentiality are assured.</i>																											
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS																									
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT		SURVEYOR RATING																							
9F.4.3.1	The Specialist Outpatient Services shall have the following features: a) the organisation and management of the clinics are planned to ensure prompt attention to patients, minimal waiting time, and avoidance of unnecessary visits by the patients; b) record keeping shall be efficient; c) an appointment or queuing system is used to manage patient consultations; d) the clinic is easily accessible including for non-ambulant patients and is easily identified through adequate signage; e) the clinic is located close to other facilities, e.g. radiology and pharmacy; f) adequate provision is made for patient comfort.																											
	<table border="1"> <tr> <td rowspan="10">EVIDENCE OF COMPLIANCE</td> <td colspan="2">1. The Specialist Outpatient Services address items (a) to (f) with evidence of but not limited to the following:</td> </tr> <tr> <td>a)</td> <td>list of services available and offered to patients;</td> </tr> <tr> <td>b)</td> <td>flow chart on work process;</td> </tr> <tr> <td>c)</td> <td>safe keeping of medical records;</td> </tr> <tr> <td>d)</td> <td>security of data in Health Information System;</td> </tr> <tr> <td>e)</td> <td>clinic appointment system;</td> </tr> <tr> <td>f)</td> <td>monitoring of waiting time;</td> </tr> <tr> <td>g)</td> <td>adequate and appropriate signage;</td> </tr> <tr> <td>h)</td> <td>floor plan indicates accessibility to supporting services and optimisation of space;</td> </tr> <tr> <td>i)</td> <td>adequate patient personal use items, e.g. wheelchair,</td> </tr> <tr> <td>j)</td> <td>adequate waiting area, rest rooms, refreshments, reading material and parking space.</td> </tr> </table>	EVIDENCE OF COMPLIANCE	1. The Specialist Outpatient Services address items (a) to (f) with evidence of but not limited to the following:		a)	list of services available and offered to patients;	b)	flow chart on work process;	c)	safe keeping of medical records;	d)	security of data in Health Information System;	e)	clinic appointment system;	f)	monitoring of waiting time;	g)	adequate and appropriate signage;	h)	floor plan indicates accessibility to supporting services and optimisation of space;	i)	adequate patient personal use items, e.g. wheelchair,	j)	adequate waiting area, rest rooms, refreshments, reading material and parking space.				
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	Facility Comments:																											

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9F.4.3.2	Adequate numbers of rooms are provided to ensure patient privacy and confidentiality for various patient care activities including: a) consultation (only one patient in a room at any time); b) conduct of minor procedures and nursing procedures; c) performance of various tests.			
	EVIDENCE OF COMPLIANCE			
	1. Adequate facilities for consultation and patient care activities that address items (a) to (c) with evidence of but not limited to the following:			
	a) privacy of patient is ensured;			
	b) procedure room appropriately equipped;			
	c) patient monitoring device is available where required;			
	d) list of procedures done.			
	Facility Comments:			

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 9F.5:		<u>SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES</u>				
STANDARD 9F.5.1		<i>The Head of Oncology Services shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Services. The Head of Oncology Services shall ensure compliance to monitoring of specific performance indicators.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9F.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Oncology Services. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.					
	EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to (f)				
		2. Records on performance improvement activities				
		3. Minutes of performance improvement meetings				
		4. Performance improvement studies				
		5. Mortality and morbidity audits with remedial actions				
		6. Records on innovation if available.				
	Facility Comments:					
9F.5.1.2	The Head of Oncology Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement activities to appropriate individual/personnel within the respective services.					
	EVIDENCE OF COMPLIANCE	1. Minutes of meetings				
		2. Letter of assignment of responsibilities				
		3. Job description				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9F.5.1.3	The Head of the Oncology Services shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility.				
	Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.				
	EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:			
		a) Training of staff			
		b) Policy on incident reporting			
		c) Methodology of incident reporting			
		d) Register/records of incidents			
		2. Completed incident reports			
		3. Root Cause Analysis			
		4. Corrective and preventive action plans			
		5. Remedial measure			
	6. Minutes of meetings				
	7. Acknowledgment by Head of Service and PIC/Hospital Director				
	8. Feedback given to staff regarding incident reporting.				
Facility Comments:					
9F.5.1.4 CORE	The staff including oncologists provide an appropriate peer group structure for performing the safety and performance improvement activities to accomplish clinical care evaluation.				
	a) The oncologists undertake clinical reviews of all risk assessments, incident reports, audits and safety and performance improvement activities: i) as a single committee for all safety and performance improvement activities; ii) in multidisciplinary committees within the Services; iii) in a variety of purpose-specific committees, such as mortality and morbidity, infection control, blood transfusion, etc.				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	b) Whatever structure is utilised, provision is made for review and analysis of the clinical work of each individual clinical service, department, unit or function.				
	EVIDENCE OF COMPLIANCE	1. Performance improvement activities			
		2. Minutes of meetings			
		3. Relevant reports and documents, e.g. clinical audit reports, incident reports, mortality and morbidity review reports, etc.			
	Facility Comments:				
9F.5.1.5 CORE	There is tracking and trending of specific performance indicators not limited to but at least three (3) of the following: a) number of mortality/morbidity audits/meetings being conducted in the department with documentation of cases discussed b) percentage of patients developed extravasation chemotherapy treatment (Target: less than 5%) c) percentage of oncology systemic therapy prescription (from prescription to administration)				
	EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored.			
		2. Records on tracking and trending analysis.			
		3. Remedial measures taken where appropriate			
	Facility Comments:				
9F.5.1.6	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.				
	EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff.			
		2. Evidence of feedback via communication on results of performance improvement activities through continuing medical education/meetings.			
		3. Minutes of service/committee meetings			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9F.5.1.7	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.					
	EVIDENCE OF COMPLIANCE	1. Documentation on performance improvement activities and performance indicators.				
		2. Policy statement on anonymity on patients and providers involved in performance improvement activities.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 9F.6: SPECIAL REQUIREMENTS – ONCOLOGY SERVICES						
STANDARD 9F.6.1 <u>RADIOTHERAPY SERVICES</u> <i>The Facility is constructed, equipped, operated and maintained in a manner that ensures appropriate radiotherapy services are available to treat cancer patients effectively taking into consideration the safety of the patients, visitors, and staff, and in accordance to relevant regulatory requirements.</i>						
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9F.6.1.1 CORE	There is documented evidence that the Facility operates under a valid license as required in accordance to the Atomic Energy Licensing Act 1984.					
	EVIDENCE OF COMPLIANCE	1. Valid license				
		2. Approval from Atomic Energy Licensing Board				
	Facility Comments:					
9F.6.1.2 CORE	The Facility providing radiotherapy shall have the minimum equipment required to carry out therapy effectively namely : a) Linear accelerator (or similar) b) Treatment planning computer c) Simulator or CT simulator or equivalent; d) Equipment, for calibration including dosimeter e) Tertiary collimation methods such as multi leaf collimators or block cutting and casting equipment					
	EVIDENCE OF COMPLIANCE	1. Availability of equipment (a) to (e) to carry out therapy.				
		Facility Comments:				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9F.6.1.3 CORE	Facility that has a brachytherapy machine or live sources, e.g. radioiodine, shall operate in accordance with the relevant laws and statutory requirements:			
	a) <u>High Dose Rate (HDR) Brachytherapy:</u>			
	i) Facilities are as specified by the appropriate authority.			
	ii) There is evidence that the HDR after loader undergoes quality assurance tests at the beginning of each treatment day, and emergency safety container and kit are always available.			
	b) <u>Low Dose Rate (LDR) Brachytherapy:</u>			
	i) There are special single rooms as specified by the appropriate authority.			
	ii) Policies and procedures are in place for staff handling these patients.			
	iii) Proper warning signs are placed on the door of the room.			
	iv) Facilities for proper storage of all radiation sources are mandatory in accordance to applicable laws.			
	(c) <u>Seed Implants</u>			
	i) Policies and procedures are in place for staff handling these patients.			
	ii) Proper warning signs are placed on the door of the room.			
	iii) Facilities for proper storage of all radiation sources are mandatory.			
	iv) Patients shall be monitored for radiation prior to discharge to ensure safe radiation levels			
EVIDENCE OF COMPLIANCE	1. Checklist for HDR brachytherapy including for daily quality assurance and treatment planning.			
	2. Calibration certificates for new sources.			
	3. Checklist for LDR brachytherapy and safe room monitoring including approved personnel access and double locks.			
	4. When brachytherapy is performed, written directives are documented for each procedure and should include the treatment site, isotope, number of sources and the planned dose to designated points.			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		5. After completion a written summary of treatment delivery should include total dose of brachytherapy and external beam therapy, date of source insertion and documentation of a radiation safety survey of the patient and room.			
		6. Items (i) to (iv) for Seed Implants should be addressed by the Facility.			
	Facility Comments:				
9F.6.1.4 CORE	There is a full time medical physicist trained in radiotherapy who conducts or supervises the calibration, dosimetry, and quality assurance in therapeutic use of radiation including teletherapy and brachytherapy.				
EVIDENCE OF COMPLIANCE	1. Availability of trained medical physicist				
	2. Specified job description				
Facility Comments:					
9F.6.1.5 CORE	There is documented evidence that all radiotherapy equipment, where applicable, complies with relevant standards. The equipment are checked and calibrated at prescribed intervals by designated personnel to ensure equipment functions at optimum/preset levels of performance.				
EVIDENCE OF COMPLIANCE	1. Checklist for daily, weekly and monthly check				
	2. Recalibration log				
Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT					
STANDARD 9F.6.2	RADIATION SAFETY <i>There is an effective Facility-wide radiation safety programme to deal with radiation hazards to patients, visitors, and staff.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9F.6.2.1 CORE	There are documented safety procedures specific to potentially hazardous areas and for hazardous substances.				
	EVIDENCE OF COMPLIANCE	1. Documented safety procedures specific to potentially hazardous areas and for hazardous substances.			
		2. Identified hazardous areas			
		3. Identified hazardous substances			
		4. On-site verification on compliance with safety procedures			
	Facility Comments:				
9F.6.2.2 CORE	Special safety measures in the form of facilities and equipment are provided for hazardous areas in accordance with requirements of local statutory authorities and applicable standards.				
	EVIDENCE OF COMPLIANCE	1. Facilities and equipment provided for hazardous areas in accordance with requirements of local statutory authorities and applicable standards.			
		2. Personal protective equipment are available.			
		3. Compliance to usage of personal protective equipment			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9F.6.2.3 CORE	A Radiation Safety Committee shall be established in accordance to the statutory Acts and Regulations and shall ensure evidence of: a) safety measures against radiation hazard for staff, patients, and visitors; b) appropriate radiation delivery by trained therapy radiographers; c) monitoring of radiation exposure of staff (special precaution for pregnant staff); d) proper disposal of waste products; e) medical examination including Full Blood Count for staff exposed to radiation once in three years and more frequent for those exposed to higher ionizing radiation.				
	EVIDENCE OF COMPLIANCE	1. Terms of Reference of Radiation Safety Committee to address items (a) to (e)			
		2. Minutes of meetings			
	Facility Comments:				
9F.6.2.4 CORE	There is evidence of safety measures against radiation hazard for patients: a) the decision to treat with radiotherapy shall be made by a qualified clinical/radiation oncologist; b) accepted treatment protocols; c) choice of machines and related equipment; d) appropriate use of machines according to specifications.				
	EVIDENCE OF COMPLIANCE	1. Safety measures against radiation hazard for patients address items (a) to (d).			
		2. Documented formal treatment planning system and quality assurance plan should be available.			
		3. At completion of treatment, the oncologist or medical officer shall review the entire chart to affirm the fulfilment of the prescription dose and document in patient's chart/folder.			
		4. Patient to be evaluated by the oncologist or medical officer at least weekly and examination be documented in the patient chart or case notes.			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	5. At completion of treatment, a follow-up plan should be documented in the patient notes. Follow-up notes should be documented.				
	Facility Comments:				
9F.6.2.5 CORE	There are safety measures against radiation hazard for staff: a) Design of work station to conform to radiation safety standards. b) Adequate radiation warning signs. c) Protective clothing and equipment (with safety interlocks, proper location of emergency buttons and related safety equipment) are provided and their usage monitored. d) Film badges/monitoring devices are used, properly maintained and detailed records are kept.				
	EVIDENCE OF COMPLIANCE	1. Safety measures against radiation hazard for staff include but not limited to items (a) to (d).			
	Facility Comments:				
9F.6.2.6 CORE	There are safety measures against radiation hazard for visitors: a) adequate signages at all premises housing radiation sources, including multilingual signs warning women of childbearing age about radiation dangers are prominently displayed; b) control the visit to patients undergoing brachytherapy treatments, e.g. the age and health status of visitors and duration of visit, etc.				
	EVIDENCE OF COMPLIANCE	1. Safety measures against radiation hazard for visitors include but not limited to items (a) and (b).			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT					
STANDARD 9F.6.3	<u>CHEMOTHERAPY SERVICES</u> <i>The Facility is constructed, equipped, operated, and maintained in a manner that ensures appropriate chemotherapy services are available to treat cancer patients effectively taking into consideration the safety of the patients, visitors, and staff, and in accordance to relevant regulatory requirements.</i>				
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9F.6.3.1 CORE	There are documented policies and procedures that chemotherapy services shall be performed within requirements that include the following: a) chemotherapy shall be prescribed and supervised by accredited and experienced oncologists; b) all patients shall be treated according to established chemotherapy protocols, and variances from protocols are monitored; c) there is evidence of collaborative care among specialists in chemotherapy, surgery, radiotherapy, and palliative medicine for optimum clinical management; d) all principal clinical support services shall be readily available, e.g. dietetics, physiotherapy, occupational therapy, counselling etc.				
	EVIDENCE OF COMPLIANCE	1. Policies and procedures which address items (a) to (d).			
		2. Compliance with policies and procedures			
		3. Patient's medical record			
		4. Patient chart review for evidence of team discussion			
	Facility Comments:				
9F.6.3.2 CORE	Privileged oncology trainees, medical officers and trained nurses with approved certification or oncologists shall deliver intravenous chemotherapy.				
	EVIDENCE OF COMPLIANCE	1. Verification of procedure performed by individual at point of care within the awarded privileging rights with evidence of privileging certificates.			
		Facility Comments:			

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
9F.6.3.3 CORE	Day care chemotherapy option is made available where there is a dedicated area for treatment, trained personnel and necessary support facilities such as pharmacy services for reconstitution of chemotherapy drugs.					
	EVIDENCE OF COMPLIANCE	1. Availability of day care service with dedicated areas.				
		2. Qualified and competent personnel				
		3. Support facilities, e.g. pharmacy services for reconstitution of chemotherapy drugs.				
	Facility Comments:					
9F.6.3.4 CORE	There shall be documented record of the treatment received by the patient, prescribed protocol of therapy, types of drugs, dosages, and dates when given or reviewed and reasons given for changes.					
	EVIDENCE OF COMPLIANCE	1. Patient's medical record documentation				
		2. Observation/patient interview during survey				
	Facility Comments:					
9F.6.3.5 CORE	There is evidence that healthcare professionals provide the patient and carer with clear, pre- and post-treatment information and possible side effects, e.g. nausea and vomiting, neutropaenic sepsis etc.					
	EVIDENCE OF COMPLIANCE	1. Patient's consent form for chemotherapy				
		2. Patient and carer orientation checklist				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9F.6.3.6 CORE	The reconstitution of chemotherapy drugs is done in a safe and appropriate environment including facility, using the correct equipment and by trained personnel in accordance with regulatory requirements.					
	EVIDENCE OF COMPLIANCE	1. Functional facilities for reconstitution of chemotherapy drugs as per National Pharmaceutical Control Bureau (BPFK).				
		2. Trained and certified pharmacist to reconstitute chemotherapy drugs.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT					
STANDARD 9F.6.4	RADIOACTIVE AND CYTOTOXIC WASTE				
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9F.6.4.1 CORE	There is evidence of safe handling and disposal of cytotoxic consumables, including the use of approved colour coded waste bags, protective clothing, and appropriate collection and storage facility prior to removal from the site, and mechanism of monitoring such handling.				
	EVIDENCE OF COMPLIANCE	1. Cytotoxic containers clearly and visibly display the cytotoxic hazard symbol.			
		2. Clearly marked chemotherapy waste receptacles are kept in all areas where cytotoxic drugs are stored, prepared or administered.			
		3. All cytotoxic drug waste is separated from general waste.			
		4. Cytotoxic waste is destroyed in an incinerator approved for the destruction of cytotoxic drugs. If incinerator not available, transported to and bury in a licensed hazardous waste dump. If the service is outsourced, the contractual agreement should include the standard operating procedures for disposal of cytotoxic waste.			
Facility Comments:					
9F.6.4.2 CORE	The labelling and disposal of scheduled waste (cytotoxic and radioactive) as defined in the Environmental Quality Act 1974 (Act 127) and subsequent amendments are implemented in accordance with the requirements of the relevant Acts. Notes/Explanation These procedures, including the removal of waste from the site, are in accordance with the requirements of the relevant authority or authorities such as The Environmental Quality Act 1974 (Act 127) and subsequent amendments and the subsidiary legislation referring to Scheduled Waste, Prescribed Premises, Prescribed Activities, Atomic Energy Licensing Act 1984.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Compliance with the Environmental Quality Act				
	Facility Comments:					
9F.6.4.3 CORE	Spillages kits shall be readily available to contain spillage of cytotoxic drugs with documented procedures regarding their usage.					
EVIDENCE OF COMPLIANCE	1.	Cytotoxic drug spill kit should be located at an easily accessible area and clearly labelled. It must be reviewed regularly to ensure its contents have not deteriorated, and have been restocked upon use.				
	2. The minimum contents of cytotoxic drug spill kit should include:					
	a)	Spill handling procedure (1)				
	b)	Cytotoxic spill caution sign (1)				
	c)	Personal protective equipment: i) Head cover (1) ii) Goggles/ full-face chemical splash shield (1) iii) Disposable N95 face mask (1) iv) Disposable gown (1) v) Chemo nitrile gloves (1 pair) vi) Surgical nitrile gloves (1 pair) vii) Booties (1)				
	d)	Brush and small dustpan (1)				
	e)	Clinical waste plastic bag labelled 'Cytotoxic waste, handle with care' (2)				
	f)	Bag ties (2)				
	g)	Forceps (1)				
	h)	Absorbent pad (12)				
	i)	Strong alkaline cleaning agent (1)				
	j)	Water (1)				
	k)	Small sharps container (1)				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		l) Cytotoxic drug spill incident report form (1)			
		Facility Comments:			

SERVICE SUMMARY	
SURVEYOR SUMMARY:	
OVERALL RATING:	
OVERALL RISK:	

SURVEY ITEM & SELF-ASSESSMENT				
SERVICE STANDARD 9G : CLINICAL SERVICES - OPHTHALMOLOGY RELATED SERVICES				
	<u>PREAMBLE</u> Ophthalmology Services play an integral role in delivering appropriate care and reducing unwarranted adverse events, as they meet the care people expect to be offered or receive, regardless of where they are treated in the Facility. <i>The Ophthalmology Services shall be organised, directed and coordinated with other services in the Facility to provide a high standard of inpatient and outpatient care to the community and cover the following:</i> <i>a) appropriateness of clinical care;</i> <i>b) unwarranted variation in care that is not explained by the clinical circumstances or personal choices of the medical practitioners in:-</i> <i>i) overuse of treatments or procedures that do not help patients get better;</i> <i>ii) underuse of care;</i> <i>iii) misuse (or errors) of doing something incorrectly and harming patients.</i> <i>In addition to the above, the Ophthalmology Services also conduct teaching and training, research and audit activities where applicable.</i>			
<u>TOPIC 9G.1:</u> <u>STANDARD 9G.1.1</u>	<u>ORGANISATION AND MANAGEMENT</u> <i>The Ophthalmology Services shall be organised, directed and coordinated with other services in the Facility to provide a high standard of inpatient and outpatient care to the community in a safe, efficient, effective, evidence based and caring manner and with due regard for the needs, dignity and privacy of patients and confidentiality of their personal information. The Ophthalmology Services shall be easily accessible and continuity of care assured.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9G.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Ophthalmology Services are clearly documented and measurable that indicates safety, quality and patient centred care. These reflect the roles and aspirations of the service and the needs of the community. These statements			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	are monitored, reviewed and revised as required accordingly and communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.				
		2. Goals and objectives of the Ophthalmology Services in line with the Facility statements are available, endorsed and dated.				
		3. Evidence of planned reviews of the above statements.				
		4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)				
		5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.				
	Facility Comments:					
9G.1.1.2 CORE	There is an organisation chart which: a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head of Ophthalmology Services, consultants, medical practitioners and staff of the Ophthalmology Services; b) reflect the relevant Ophthalmology subspecialties services/units; c) is accessible to all staff and clients; d) includes off-site services if applicable e) is revised when there is a major change in any of the following: i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns.					
EVIDENCE OF COMPLIANCE	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head of Ophthalmology Services, relevant Ophthalmology subspecialties services/units, consultants, medical practitioners and staff of the Ophthalmology Services.					
	2. Organisation chart of the service is endorsed, dated and accessible.					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).				
	Facility Comments:				
9G.1.1.3	The Governing Body shall ensure that Ophthalmology Services are organised in such a way as to: a) facilitate the provision of Ophthalmology services to patients in the Facility in a safe, efficient, effective, and caring manner and with due regard for the needs, dignity and privacy of patients and confidentiality of their personal information; b) assure continuity of care; c) address the professional needs of the medical practitioners; d) ensure that the medical practitioners are involved in the formulation of policies and procedures concerning patient care appropriate to the scope of services of the Facility.				
	EVIDENCE OF COMPLIANCE 1. Departmental/Service operational policies that address (a) to (d). 2. Medical Staff By-Laws 3. Evidence of involvement of medical practitioners in the formulation of policies and procedures concerning patient care. 4. Involvement of Head of the Service in the Medical and Dental Advisory Committee/Medical Advisory Committee and ward meetings. 5. Minutes of meetings 6. Proper and adequate equipment according to current standards.				
	Facility Comments:				
9G.1.1.4	There is a mechanism to ensure effective interaction between the Ophthalmology Services and the Governing Body on all clinical aspects of healthcare and other relevant matters in the Facility. This mechanism is defined in the policies of the Governing Body and is accomplished through:				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	a) the appointment of a medical practitioner as the Head of Ophthalmology Services delineating his/her authority, responsibilities and accountabilities in a written document according to the relevant Acts to manage and control the Ophthalmology Services;					
	b) Medical and Dental Advisory Committee (MDAC) to advise the Governing Body on issues related to clinical governance, i.e. in planning, coordinating, implementation, control and to improve activities relating to Ophthalmology Services.					
	EVIDENCE OF COMPLIANCE				1. Letter of appointment/assignment and delineation of duties and responsibilities of the Head of Service.	
	2. Letter of appointment and Terms of Reference as member of the Medical and Dental Advisory Committee/Medical Advisory Committee.					
	3. Minutes of meetings of MDAC/Management					
	Facility Comments:					
9G.1.1.5 CORE	The Head of Ophthalmology Services has:					
	a) representation of the Service in relevant committees;					
	b) representation of the Service in clinical staff liaison meetings;					
	c) involvement and provide regular input to the Senior Management Team.					
	EVIDENCE OF COMPLIANCE				1. Letter of representation of the Head of Service in committees and subcommittees where relevant, e.g.Blood Transfusion Committee, Medical Records Committee, Hospital Infection and Antibiotic Control Committee, etc.	
	2. Minutes of meetings of committees					
3. Minutes of meeting of Senior Management Team.						
Facility Comments:						

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9G.1.1.6	The assessment, planning, direction, evaluation and continuity of clinical care are the responsibility of medical practitioners managing individual patients, thus ensuring clinical independence.					
	EVIDENCE OF COMPLIANCE	1. Medical Staff By-Laws; clause indicate clinical care responsibility of medical practitioners.				
		2. Documented evidence of clinical notes in the patient's medical record; e.g. documentation on assessment, planning, direction, evaluation and continuity of clinical care, valid name stamp of medical practitioner.				
	Facility Comments:					
9G.1.1.7	The Head of Ophthalmology Services shall be involved for the following aspects of management of the services: a) the preparation of budget and ensuring that expenditure remains within the budget allocated; b) human resource management and development; c) development of policies and procedures and ensuring compliance to them; d) facility and equipment management; e) safety and performance improvement activities and risk management.					
	EVIDENCE OF COMPLIANCE	1. Evidence of (a) to (e) in the minutes of meetings of Ophthalmology Services indicate the involvement of Head of Service.				
		2. Endorsement of policies and procedures				
		3. Request for allocation of budget and staffing				
		4. Implementation of performance improvement activities				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9G.1.1.8	Regular staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Ophthalmology Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.				
	EVIDENCE OF COMPLIANCE	1. Minutes are accessible, disseminated and acknowledged by the staff.			
		2. Attendance list of members with adequate representatives of the service.			
		3. Frequency of meetings as scheduled-a minimum of two (2) meetings in a year			
		4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).			
	Facility Comments:				
9G.1.1.9	Where there are medical practitioners in training, there is evidence that: a) their responsibilities for patient care are documented; b) their training needs are identified; c) appropriate supervision and training are given to the medical practitioners concerned.				
	EVIDENCE OF COMPLIANCE	1. Structured training programmes for medical practitioners are in place.			
		2. Training timetable, continuing medical education and attendances list			
		3. Assessment reports			
		4. Log books/e-Log book			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9G.1.1.10	Appropriate statistics and records shall be maintained in relation to the provision of Ophthalmology Services and used for managing the services and patient care purposes.					
	EVIDENCE OF COMPLIANCE	1. Records are available but not limited to the following:				
		a) workload/census for inpatients and outpatients;				
		b) annual report;				
		c) accident/incident reports;				
		d) staffing number and staff profile;				
		e) staff training records;				
		f) data on performance improvement activities, including performance indicators.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT				
TOPIC 9G.2:		<u>HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT</u>		
STANDARD <u>9G.2.1</u>		<u>CREDENTIALING AND PRIVILEGING</u> <i>The Ophthalmology Services shall be directed by a qualified and competent medical practitioner, and staffed by suitably qualified and competent clinical staff to achieve the goals and objectives of the Surgical Services.</i>		
			SURVEYOR FINDINGS	
	CRITERIA FOR COMPLIANCE:	SELF RATING	AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9G.2.1.1 CORE	There is documented evidence of appropriate training and competency for the granting of clinical privileging. The criteria for determining privileges are specified and documented. There is a structured process to ensure the stated criteria are uniformly applied to all applicants. These include: a) the criteria are designed to assure that patients will receive safe and quality care; b) the criteria for individual procedures are documented in detail; e.g. competency records/log books(e-log book), application from the individual practitioner, recommendations from peer/referee and minutes of meeting; c) competency for each performance is dated, verified and signed by the supervisors; d) the period of time (two years or when needed) for which the privileges are to be granted is specified; e) current registration with the local professional registration bodies, e.g. Malaysian Medical Council, National Specialist Register (NSR), Nursing Board, Medical Assistant Board, Malaysian Optical Council and Pharmacy Board; f) peer recommendations are taken into account when privileges are being considered; g) the recommendations of the relevant department and/or major professional services for privileges to be granted are taken into consideration.			
	EVIDENCE OF COMPLIANCE			
	1. Documented policies and procedures are established to govern the credentialing and privileging processes which include items (a) to (g).			
	2. Compliance with policy and criteria for credentialing and privileging			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		3. Annual Practising Certificate (APC), National Specialist Register (NSR) certificate and privileging certificate.				
		4. Recommendations from peer/referee				
		5. Availability of the list of procedures including core procedures as per discipline specific and procedures requiring credentialing and privileging				
	Facility Comments:					
9G.2.1.2	Clinical staff performs within the privileges conferred.					
CORE	EVIDENCE OF COMPLIANCE	1. Verification of procedures performed by individuals at point of care within the awarded privileging rights with evidence of:				
		a) list of procedures privileged;				
		b) accessibility of this list be made available at point of care.				
		c) operating list;				
		d) operating notes/clinical notes.				
	Facility Comments:					
9G.2.1.3	There are written and dated specific job descriptions for all categories of staff that include: a) qualification, training, experience and certification required for the position; b) lines of authority; c) accountability, functions, and responsibilities; d) reviewed when required and when there is a major change in any of the following: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations. e) administrative and clinical functions.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e).					
		2. Job description includes specialisation skills					
		3. Relevant privileges granted where applicable					
		4. The job description is acknowledged by the staff and signed by the Head of Service and dated.					
	Facility Comments:						

SURVEY ITEM & SELF-ASSESSMENT								
STANDARD 9G.2.2	STAFF TRAINING, EDUCATION, APPRAISAL AND RESEARCH The Facility and all staff shall demonstrate an ongoing commitment to continuing medical education.							
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
9G.2.2.1	There are continuing education activities for staff including medical practitioners to pursue professional interests and to prepare for current and future changes in practice.							
	EVIDENCE OF COMPLIANCE	1. Training calendar includes in-house/external courses/ workshop/conferences						
		2. Contents of training programme						
		3. Training records on continuing education activities are kept and maintained for each staff including training in life support.						
		4. Certificate of attendance/degree/post basic training						
	Facility Comments:							
9G.2.2.2	The educational needs of staff and the Facility, as evidenced by the results of medical-care evaluation such as incident reports, performance improvement studies and complaints, are taken into consideration when the content and structure of educational activities are planned.							
	EVIDENCE OF COMPLIANCE	1. Evidence of inclusion of results of audit activities, e.g. mortality and morbidity reviews, incident reporting, etc in educational activities.						
		2. Evidence of improvement made from corrective or preventive measures from incident reports.						
	Facility Comments:							
9G.2.2.3	In a Facility where undergraduate medical, nursing and allied health training programmes are conducted, the Facility shall ensure that there are sufficient skilled trained staff to provide clinical supervision of students.							

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Sufficient skilled trained staff to provide clinical supervision as per terms of Memorandum of Understanding.				
	Facility Comments:					
9G.2.2.4	There is evidence of training needs assessment and staff development plan which provides the knowledge and skills required for staff to maintain competency in their current positions and future advancement.					
	EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and gaps identified.				
		2. A staff development plan based on training needs assessment is available.				
		3. Training schedule/calendar is in place.				
		4. Training module				
	Facility Comments:					
9G.2.2.5	Staff including medical practitioners receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.					
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff including medical practitioner is completed upon probationary period and as an annual exercise.				
	Facility Comments:					
9G.2.2.6	Where appropriate the Facility shall endeavour to undertake clinical research using available resources.					
	EVIDENCE OF COMPLIANCE	1. Documented evidence of research activities, e.g. protocol, policies, consent, etc.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT					
STANDARD 9G.2.3	<u>STAFFING LEVEL AND STAFF COMPETENCY</u> <i>The Head and staff of the Surgical Services including medical practitioners are individuals qualified by education, training and experience commensurate with the requirements of the various positions and relevant laws.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9G.2.3.1	Deployment of all service providers for Ophthalmology Services takes the following factors into consideration: a) the number of persons deployed is proportional to the number of patients being cared for as in the regulatory requirements and for the intensity of care provided; b) the categories of service providers based on qualifications and experience providing care reflect the complexity of clinical problems being managed; c) staffing needs shall take into consideration absences due to leave or illness; double shift duties by clinical staff shall be documented and monitored; d) adequate staffing levels of appropriate competency shall be maintained throughout the hours the services are in operation. Where services need to be provided on a 24-hour basis, staffing level reflects the intensity of activities during each shift; e) where it is not possible to have service providers on duty on site, e.g. after working hours, provision is made for relevant medical practitioner to be available on call.				
	EVIDENCE OF COMPLIANCE	1. Documentation and planning on deployment of staff that includes but not limited to (a) to (e) with evidence of:			
		a) deployment based on staff to patient ratio, bed occupancy rate and complexity of cases;			
		b) special skills/training of staff;			
		c) contingency plan during acute shortage;			
		d) duty roster.			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT											
STANDARD 9G.2.4	STAFF ORIENTATION <i>A structured orientation programme introduces new staff to their services, operational policies and relevant aspects of the Facility to prepare them for their roles and responsibilities.</i>										
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS								
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING							
9G.2.4.1	There is a structured orientation programme for all newly appointed staff to the Ophthalmology Services including medical practitioners and for those new to specific areas that include the following: a) explanation of the goals, objectives, policies and procedures of the Facility and those of the Ophthalmology Services; b) lines of authority and areas of responsibility; c) explanation of particular duties and functions; d) explanation of the methods of assigning clinical care and the standards of clinical practice; e) handover communication; f) processes for resolving practice dilemmas; g) information about safety procedures; h) training in basic/advanced life support techniques; i) methods of obtaining appropriate resource materials; j) staff appraisal procedures for the Ophthalmology Services; k) education on Patient Centred Care l) education on MSQH Standards requirements. m) information about care and treatment to limit barriers such as accessibility, languages, spiritual and cultural beliefs etc at least two (2) languages; n) educate on management of clinical alarm system (cross reference to nursing policy);										
	<table><tr><td rowspan="3">EVIDENCE OF COMPLIANCE</td><td>1. Policy requiring all new staff to attend a structured orientation programme</td><td></td></tr><tr><td>2. There is Ophthalmology Services orientation programme with relevant topics not limited to topics covered from (a) to (n).</td><td></td></tr><tr><td>3. Attendance list</td><td></td></tr></table>	EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme		2. There is Ophthalmology Services orientation programme with relevant topics not limited to topics covered from (a) to (n).		3. Attendance list				
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	3. Attendance list										
	Facility Comments:										

SURVEY ITEM & SELF-ASSESSMENT					
<u>TOPIC 9G.3:</u>	<u>POLICIES AND PROCEDURES</u>				
<u>STANDARD 9G.3.1</u>	<u>DEVELOPMENT, DERIVATION AND DOCUMENTATION</u> <i>There are written and dated policies and procedures for all activities of the Ophthalmology Services. These policies and procedures reflect current standards of medical practice, relevant regulations, statutory requirements, and the purposes of the services. These policies and procedures, terms of reference, by-laws, rules or regulations, state how the clinical staff including medical practitioners regulate themselves and provide patient care.</i>				
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9G.3.1.1 CORE	There are written policies and procedures for the Ophthalmology Services which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated.				
	There is a mechanism for and evidence of a periodic review at least once in every three years.				
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for the service.			
		2. Policies and procedures are consistent with regulatory requirements and current standard practices.			
		3. Evidence of periodic review of policies and procedures.			
		4. The policies and procedures are endorsed and dated.			
Facility Comments:					
9G.3.1.2	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved. Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.				
		2. Minutes of meeting with evidence of cross reference with other departments				
		3. Documented cross departmental policies				
	Facility Comments:					
9G.3.1.3 CORE	The policies and procedures documentation shall address at least the following topics and any others as required by relevant standards and laws: a) description of the organisational structure of the Surgical Services; b) clinical practice guidelines; c) clinical documentation includes pain as the 5 th vital sign where appropriate; d) handover communication; e) drug prescription, dispensing and administration; f) blood transfusion; g) continuing of care including regular review of patient, review of investigation results, discharge (planned or At Own Risk), referrals and escort as necessary; h) pain management; i) management of patients under police custody/prisoner; j) management of cases with an infectious disease including notification of notifiable diseases; k) the responsibilities of the staff including medical practitioners in relation to internal and external disasters are documented, and known to the staff (contingency plan); n) incident reports shall be compiled, investigated, discussed and recorded and action plans implemented; l) end of life care; m) management of a death; n) safe use of lasers or other optic radiation devices (cross reference to standard 3); o) sedation policy and procedures cross reference to anaesthetist standard 10; p) management of high risk patients or high risk services-emergency, comatose, immunosuppressive,on life support,on dialysis, with communicable disease, in restraints, receiving chemotherapy,vulnerable patients and palliative care (nursing policy-standard 4); q) register of implantable medical devices registered under - biomedical standard 3					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures that address but not limited to items (a) to (q).				
	Facility Comments:					
9G.3.1.4	Current policies and procedures are communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings				
		2. Circulation list and acknowledgement				
	Facility Comments:					
9G.3.1.5 CORE	There is evidence of compliance with policies and procedures.					
	EVIDENCE OF COMPLIANCE	1. Compliance with policies and procedures through:				
		a) interview of staff on practices;				
		b) verify with observation on practices;				
		c) results of audit on practices;				
		d) practices in line with established policies and procedures.				
	Facility Comments:					
9G.3.1.6	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.					
	EVIDENCE OF COMPLIANCE	1. Copies of relevant policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
9G.3.1.7	The services shall operate on a 24-hour basis providing a level of care appropriate to the activities of the patients in the Facility.							
	EVIDENCE OF COMPLIANCE	1. Operational policy on 24-hour services						
		2. Staffing level reflects good mix of experienced staff and the intensity of activities during each shift.						
		3. On-call roster is dated and authorised.						
	Facility Comments:							

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 9G.4:		<u>FACILITIES AND EQUIPMENT</u>				
STANDARD <u>9G.4.1</u>		<i>The Head of Ophthalmology Services shall ensure adequate facilities and equipment that are safe and appropriate are available for the staff to function effectively and to meet the goals and objectives of the Ophthalmology Services.</i>				
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9G.4.1.1	There are adequate and appropriate facilities and equipment with proper utilisation of space to enable staff to carry out their professional, teaching and administrative functions.					
	EVIDENCE OF COMPLIANCE	1. Adequate and proper utilisation of space.				
		2. Appropriate type of equipment to match the complexity of services.				
		3. Adequate facilities and equipment at each patient care area for safe care. (e.g. defibrillators, emergency cart, hand washing facilities etc)				
		4. Easy access and clear exit routes				
		5. Absence of overcrowding				
	Facility Comments:					
9G.4.1.2	Existing facilities shall take cognisance of the safety of staff and patients.					
	EVIDENCE OF COMPLIANCE	1. Design and layout of the unit, e.g. wards, treatment rooms, dirty and clean utility rooms, access, lighting, signage, etc address the safety aspects of patients and staff.				
		2. Adequate equipment and supplies for Ophthalmology Services, e.g. emergency trolley, functioning patient call bell,				
		3. Equipment should have scheduled planned preventive maintenance (PPM).				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9G.4.1.3	Suitable and adequate forms of communication and intercommunication systems and equipment are provided to enable clinical staff to communicate among themselves and with the other members of the healthcare team.				
	EVIDENCE OF COMPLIANCE	1. Appropriate telecommunication modalities available for daily operation and during emergencies.			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT								
STANDARD 9G.4.2	FACILITIES AND EQUIPMENT FOR PATIENT CARE Adequate facilities and equipment shall be available to provide safe and effective patient care.							
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
9G.4.2.1	Facilities are suitably located to facilitate easy access and to provide an atmosphere of user, environmental and ‘disabled’ friendly.							
	EVIDENCE OF COMPLIANCE	1. Floor plan indicates accessibility and patient and user friendly.						
		2. Feedback from patient satisfaction survey						
		3. Incident reporting relating to facilities if any						
	Facility Comments:							
9G.4.2.2	Equipment, both for emergency and non-emergency usage, shall be appropriate to the level of care.							
	EVIDENCE OF COMPLIANCE	1. Availability of emergency and non-emergency equipment appropriate to level of care, such as defibrillator, emergency trolley, suction machine, electrocardiogram (ECG) machine, infusion or syringe pump, vital sign monitor, etc.						
		2. Scheduled checking of items in emergency trolley						
	Facility Comments:							
9G.4.2.3	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.							
	EVIDENCE OF COMPLIANCE	1. Testing, commissioning and calibration records (certificates or stickers)						
		2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as evidence of compliance to the relevant standards and Acts.						
	Facility Comments:							

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9G.4.2.4 CORE	There is evidence that the facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.					
	EVIDENCE OF COMPLIANCE	1. Planned Preventive Maintenance records such as schedule, stickers, etc.				
		2. Planned Replacement Programme where applicable				
		3. Complaint records				
		4. Asset inventory				
	Facility Comments:					
9G.4.2.5	Where specialised equipment is used, there is evidence that only staff who are trained and privileged by the Facility operate such equipment.					
	EVIDENCE OF COMPLIANCE	1. User training records				
		2. Competency assessment record				
		3. Letter of privileging right				
		4. List of staff trained and privileged to operate specialised equipment for example phacoemulsification, vitrectomy, Optical Coherence Tomography etc				
	Facility Comments:					
9G.4.2.6	Equipment is upgraded (based on evidence) from time to time so as to keep pace with advancement in operative and diagnostic techniques and technology.					
	EVIDENCE OF COMPLIANCE	1. Equipment are being replaced and upgraded to meet current standard of care and advancement in technology in a planned and systematic manner.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT				
STANDARD 9G.4.3	<u>FACILITIES FOR OPHTHALMOLOGY OUTPATIENT SERVICES</u> <i>Where specialist outpatient services are provided, there are adequate outpatient clinics to enable the provision of safe and effective patient care; and patient privacy and confidentiality are assured.</i>			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT SURVEYOR RATING
9G.4.3.1	The Specialist Ophthalmology Outpatient Services shall have the following features: a) the organisation and management of the clinics are planned so as to ensure prompt attention to patients, minimal waiting time, and avoidance of unnecessary visits by the patients; b) record keeping shall be efficient; c) an appointment or queuing system is used to manage patient consultations; d) the clinic is easily accessible including for non-ambulant patients and is easily identified through adequate signage; e) the clinic is located close to other facilities, e.g. radiology, laboratories and pharmacy; f) adequate provision is made for patient comfort.			
	EVIDENCE OF COMPLIANCE	1. The Specialist Ophthalmology Outpatient Services address (a) to (f) with evidence of but not limited to the following:		
		a) list of services available and offered to patients;		
		b) flow chart on work process;		
		c) safe keeping of medical records;		
		d) security of data in Health Information System		
		e) clinic appointment system;		
		f) monitoring of waiting time;		
		g) adequate and appropriate signage;		
		h) floor plan indicates accessibility to supporting services and optimisation of space;		
		i) adequate patient personal use items, e.g. wheelchair, etc;		

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		j) adequate waiting area, rest rooms, refreshments, reading material and parking space.				
	Facility Comments:					
9G.4.3.2	Adequate numbers of rooms are provided to ensure patient privacy and confidentiality for various patient care activities including: a) consultation (not more than one patient in a room at any time); b) conduct of minor procedures and nursing procedures; maintain a register of procedures performed; c) performance of various tests. d) specified room for laser and optic radiation procedures –(cross reference with standard 3)					
	EVIDENCE OF COMPLIANCE	1. Adequate facilities for consultation and patient care activities that address (a) to (c) with evidence of but not limited to the following:				
		a) privacy of patient is ensured;				
		b) procedure room appropriately equipped;				
		c) patient monitoring device is available where required;				
		d) list of procedures done.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 9G.5: SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES						
STANDARD 9G.5.1 <i>The Head of Ophthalmology Services shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Ophthalmology Services. The Head of Ophthalmology Services shall ensure compliance to monitoring of specific performance indicators.</i>						
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9G.5.1.1 CORE	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Ophthalmology Services. The process includes: a) Planned activities b) Data collection eg Problem Oriented Medical Records (manual/electronic) c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.					
EVIDENCE OF COMPLIANCE	1.	Planned performance improvement activities include (a) to (f)				
	2.	Records on performance improvement activities				
	3.	Minutes of performance improvement meetings				
	4.	Performance improvement studies				
	5.	Mortality and morbidity audits with remedial actions				
	6.	Records on innovation if available.				
Facility Comments:						
9G.5.1.2	The Head of Ophthalmology Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement activities to appropriate individual / personnel within the respective services.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes of meetings				
		2. Letter of assignment of responsibilities				
		3. Job description				
	Facility Comments:					
9G.5.1.3	The Head of Ophthalmology Services shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility. Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.					
	EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:				
		a) Training of staff				
		b) Policy on incident reporting				
		c) Methodology of incident reporting				
		d) Register/records of incidents				
		2. Completed incident reports				
		3. Root Cause Analysis				
		4. Corrective and preventive action plans				
		5. Remedial measure				
		6. Minutes of meetings				
		7. Acknowledgment by Head of Service and PIC/Hospital Director				
		8. Feedback given to staff regarding incident reporting.				
	Facility Comments:					
9G.5.1.4 CORE	The staff including medical practitioners provide an appropriate peer group structure for performing the safety and performance improvement activities to accomplish clinical care evaluation.					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	a) The medical practitioners undertake clinical reviews of all risk assessments, incident reports, audits and safety and performance improvement activities: i) as a single committee for all safety and performance improvement activities; ii) in multidisciplinary committees within the service; iii) in a variety of purpose-specific committees, such as mortality and morbidity, infection control, blood transfusion, etc. b) Whatever structure is utilised, provision is made for review and analysis of the clinical work of each individual clinical service, department, unit or function.					
	EVIDENCE OF COMPLIANCE				1. Performance improvement activities	
					2. Minutes of meetings	
					3. Relevant reports and documents, e.g. clinical audit reports, incident reports, mortality and morbidity review reports, etc.	
	Facility Comments:					
9G.5.1.5 CORE	There is tracking and trending of specific performance indicators as follows: a) Percentage of patients developed infectious endophthalmitis following cataract surgery b) Percentage of patients without pre-existing ocular co-morbidity obtained visual acuity of 6/12 or better within (<) 3 months following cataract surgery					
EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored.					
	2. Records on tracking and trending analysis.					
	3. Minutes of mortality/morbidity audits meetings					
	4. Remedial measures taken where appropriate					
Facility Comments:						
9G.5.1.6	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.					
EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff.					
	2. Evidence of feedback via communication on results of performance improvement activities through continuing medical education/meetings.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	3. Minutes of service/unit/committee meetings					
	Facility Comments:					
9G.5.1.7	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.					
	EVIDENCE OF COMPLIANCE	1. Documentation on performance improvement activities and performance indicators.				
		2. Policy statement on anonymity on patients and providers involved in performance improvement activities.				
	Facility Comments:					

SURVEYOR SUMMARY:

OVERALL RISK:

9SURVEY ITEM & SELF-ASSESSMENT				
SERVICE STANDARD 9H : CLINICAL SERVICES - OTORHINOLARYNGOLOGY				
	<u>PREAMBLE</u> <i>Otorhinolaryngology Services play an integral role in delivering appropriate care and reducing unwarranted adverse events, as they meet the care people expect to be offered or receive, regardless of where they are treated in the Facility.</i> <i>The Otorhinolaryngology Service shall be organised, directed and coordinated with other services in the Facility in particular of audiology and speech therapy services to provide a high standard of inpatient and outpatient care to the community and cover the following:</i> <i>a) appropriateness of clinical care;</i> <i>b) unwarranted variation in care that is not explained by the clinical circumstances or personal choices of the medical practitioners in:-</i> <i>i) overuse of treatments or procedures that do not help patients get better;</i> <i>ii) underuse of care;</i> <i>iii) misuse (or errors) of doing something incorrectly and harming patients.</i> <i>In addition to the above, the Otorhinolaryngology Service also conduct teaching and training, research and audit activities where applicable.</i>			
<u>TOPIC 9H.1:</u> <u>STANDARD 9H.1.1</u>	<u>ORGANISATION AND MANAGEMENT</u> <i>The Otorhinolaryngology Service shall be organised, directed and coordinated with other services as above in the Facility to provide a high standard of inpatient and outpatient care to the community in a safe, efficient, effective, evidence based and caring manner and with due regard for the needs, dignity and privacy of patients and confidentiality of their personal information. The Otorhinolaryngology Service shall be easily accessible and continuity of care assured.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9H.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Otorhinolaryngology Service are clearly documented and measurable that indicates safety, quality and patient centred care. These reflect the roles and aspirations of the service and the needs of the community. These statements			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	are monitored, reviewed and revised as required accordingly and communicated to all staff.				
	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.			
		2. Goals and objectives of the Otorhinolaryngology Services in line with the Facility statements are available, endorsed and dated.			
		3. Evidence of planned reviews of the above statements.			
		4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)			
		5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.			
	Facility Comments:				
9H.1.1.2 CORE	There is an organisation chart which: a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head of Otorhinolaryngology Service, consultants, medical practitioners and staff of the Otorhinolaryngology Service; b) reflect the relevant subspecialties services/units and allied health services (Audiology and Speech Therapy); c) is accessible to all staff and clients; d) is revised when there is a major change in any of the following: i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	e) Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head of Otorhinolaryngology Service, relevant subspecialties services/units, consultants, medical practitioners , allied health services (Audiology and Speech Therapy);and staff of the Otorhinolaryngology Services.				
		1. Organisation chart of the service is endorsed, dated and accessible.				
		2. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).				
	Facility Comments:					
9H.1.1.3	The Governing Body shall ensure that Otorhinolaryngology Service are organised in such a way as to: a) facilitate the provision of Otorhinolaryngology service to patients in the Facility in a safe, efficient, effective, and caring manner and with due regard for the needs, dignity and privacy of patients and confidentiality of their personal information; b) assure continuity of care; c) address the professional needs of the medical practitioners; d) ensure that the medical practitioners are involved in the formulation of policies and procedures concerning patient care appropriate to the scope of services of the Facility.					
EVIDENCE OF COMPLIANCE	1. Departmental/Service operational policies that address (a) to (d).					
	2. Medical Staff By-Laws					
	3. Evidence of involvement of medical practitioners in the formulation of policies and procedures concerning patient care.					
	4. Involvement of Head of the Service in the Medical and Dental Advisory Committee/Medical Advisory Committee and ward meetings.					
	5. Minutes of meetings					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	6. Proper and adequate facilities and equipment according to current standards.				
	Facility Comments:				
9H.1.1.4	There is a mechanism to ensure effective interaction between the Otorhinolaryngology Service and the Governing Body on all clinical aspects of healthcare and other relevant matters in the Facility. This mechanism is defined in the policies of the Governing Body and is accomplished through: a) the appointment of a medical practitioner as the Head of Otorhinolaryngology Service delineating his/her authority, responsibilities and accountabilities in a written document according to the relevant Acts to manage and control the Otorhinolaryngology Service; b) Medical and Dental Advisory Committee (MDAC) to advise the Governing Body on issues related to clinical governance, i.e. in planning, coordinating, implementation, control and to improve activities relating to Otorhinolaryngology Service.				
	EVIDENCE OF COMPLIANCE				
	1. Letter of appointment/assignment and delineation of duties and responsibilities of the Head of the Service.				
	2. Letter of appointment and Terms of Reference as member of the Medical and Dental Advisory Committee/Medical Advisory Committee.				
	3. Minutes of meetings of MDAC/Management				
	Facility Comments:				
9H.1.1.5 CORE	The Head of Otorhinolaryngology Service has: a) representation of the Service in committees and subcommittees where relevant; b) representation of the Service in clinical staff liaison meetings; c) involvement and provide regular input to the Senior Management Team.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Letter of representation of the Head of Service in committees and subcommittees where relevant, e.g.Blood Transfusion Committee, Medical Records Committee, Hospital Infection and Antibiotic Control Committee, Credentialing and privileging Committee, Operating Theatre committee etc.				
		2. Minutes of meetings of committees				
		3. Minutes of meeting of Senior Management Team.				
	Facility Comments:					
9H.1.1.6	The assessment, planning, direction, evaluation and continuity of clinical care are the responsibility of medical practitioners managing individual patients, thus ensuring clinical independence.					
	EVIDENCE OF COMPLIANCE	1. Medical Staff By-Laws; clause indicate clinical care responsibility of medical practitioners.				
		2. Documented evidence of clinical notes in the patient's medical record; e.g. documentation on assessment, planning, direction, evaluation and continuity of clinical care, valid name stamp of medical practitioner.				
	Facility Comments:					
9H.1.1.7	The Head of Otorhinolaryngology Service shall be involved for the following aspects of management of the services:					
	a) the preparation of budget and ensuring that expenditure remains within the budget allocated; b) human resource management and development; c) development of policies and procedures and ensuring compliance to them; d) facility and equipment management; e) safety and performance improvement activities and risk management.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Evidence of (a) to (e) in the minutes of meetings of Otorhinolaryngology Service indicate the involvement of Head of Service.				
		2. Endorsement of policies and procedures				
		3. Request for allocation of budget and staffing				
		4. Implementation of performance improvement activities				
	Facility Comments:					
9H.1.1.8	EVIDENCE OF COMPLIANCE	1. Minutes are accessible, disseminated and acknowledged by the staff.				
		2. Attendance list of members with adequate representatives of the service.				
		3. Frequency of meetings as scheduled.				
		4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).				
	Facility Comments:					
9H.1.1.9	Where there are medical practitioners in training, there is evidence that:					
	a) their responsibilities for patient care are documented; b) their training needs are identified; c) appropriate supervision and training are given to the medical practitioners concerned.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	EVIDENCE OF COMPLIANCE	1. Structured training programmes for medical practitioners are in place.					
		2. Training timetable, continuing medical education and attendances list					
		3. Assessment reports					
		4. Log books					
	Facility Comments:						
9H.1.1.10	Appropriate statistics and records shall be maintained in relation to the provision of Otorhinolaryngology Service and used for managing the services and patient care purposes.						
	EVIDENCE OF COMPLIANCE	1. Records are available but not limited to the following:					
		a) workload/census for inpatients and outpatients;					
		b) annual report;					
		c) accident/incident reports;					
		d) staffing number and staff profile;					
		e) staff training and competency records;					
	f) data on performance improvement activities, including performance indicators.						
	Facility Comments:						

SURVEY ITEM & SELF-ASSESSMENT				
TOPIC 9H.2:	<u>HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT</u>			
STANDARD 9H.2.1	<u>CREDENTIALING AND PRIVILEGING</u> <i>The Otorhinolaryngology Service shall be directed by a qualified and competent medical practitioner, and staffed by suitably qualified and competent clinical staff to achieve the goals and objectives of the Otorhinolaryngology Service.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9H.2.1.1 CORE	There is documented evidence of appropriate training and competency for the granting of clinical privileging. The criteria for determining privileges are specified and documented. There is a structured process to ensure the stated criteria are uniformly applied to all applicants. These include:			
	a) the criteria are designed to assure that patients will receive safe and quality care; b) the criteria for individual procedures are documented in detail; e.g. competency records/log books, application from the individual practitioner, recommendations from peer/referee and minutes of meeting; c) competency for each performance is dated, verified and signed by the supervisors; d) the period of time for which the privileges are to be granted is specified; e) current registration with the local professional registration bodies, e.g. Malaysian Medical Council, National Specialist Register (NSR); f) peer recommendations are taken into account when privileges are being considered; g) the recommendations of the relevant department and/or major professional services for privileges to be granted are taken into consideration.			
	1. Documented policies and procedures are established to govern the credentialing and privileging processes which include items (a) to (g).			
	2. Compliance with policy and criteria for credentialing and privileging			
	3. Annual Practising Certificate (APC), National Specialist Register (NSR) certificate and privileging certificate.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		4. Recommendations from peer/referee				
		5. Availability of the list of procedures requiring credentialing and privileging.				
		6. Availability of list of procedures to include core procedures specific to the disciplines performed by medical officers; competency records/log books.				
	Facility Comments:					
9H.2.1.2 CORE	Documented evidence of privileges conferred by the Governing Body is available and accessible to relevant staff at point of care.					
	EVIDENCE OF COMPLIANCE	1. Formal letter of assignment or certificate of privileging with stipulated timeline are issued and reviewed accordingly.				
		2. Updated list of staff with privileges conferred is made accessible at point of care.				
	Facility Comments:					
9H.2.1.3	Clinical staff performs within the privileges conferred.					
	EVIDENCE OF COMPLIANCE	1. Verification of procedures performed by individuals at point of care within the awarded privileging rights with evidence of:				
		a) list of procedures privileged;				
		b) operating list;				
		c) operating notes/clinical notes.				
	Facility Comments:					
9H.2.1.4	There are written and dated specific job descriptions for all categories of staff that include:					
	a) qualification, training, experience and certification required for the position;					
	b) lines of authority;					
	c) accountability, functions, and responsibilities;					
	d) reviewed when required and when there is a major change in any of the following:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations.					
	e) administrative and clinical functions.					
	EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e).				
		2. Job description includes specialisation skills				
		3. Relevant privileges granted where applicable				
		4. The job description is acknowledged by the staff and signed by the Head of Service and dated.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
STANDARD 9H.2.2	<u>STAFF TRAINING, EDUCATION, APPRAISAL AND RESEARCH</u> <i>The Facility and all staff shall demonstrate an ongoing commitment to continuing medical education.</i>					
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9H.2.2.1	There are continuing education activities for staff including medical practitioners to pursue professional interests and to prepare for current and future changes in practice.					
	EVIDENCE OF COMPLIANCE	1. Training calendar includes in-house/external courses/workshop/conferences				
		2. Contents of training programme				
		3. Training records on continuing education activities are kept and maintained for each staff including training in life support.				
		4. Certificate of attendance/degree/post basic training				
	Facility Comments:					
9H.2.2.2	The educational needs of staff and the Facility, as evidenced by the results of medical-care evaluation such as incident reports, performance improvement studies and complaints, are taken into consideration when the content and structure of educational activities are planned.					
	EVIDENCE OF COMPLIANCE	1. Evidence of inclusion of results of audit activities, e.g. mortality and morbidity reviews, incident reporting, etc in educational activities.				
		2. Evidence of improvement made from corrective or preventive measures from incident reports.				
	Facility Comments:					
9H.2.2.3	In a Facility where undergraduate medical, nursing and allied health training programmes are conducted, the Facility shall ensure that there are sufficient skilled trained staff to provide clinical supervision of students.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Sufficient skilled trained staff to provide clinical supervision as per terms of Memorandum of Understanding.				
	Facility Comments:					
9H.2.2.4	There is evidence of training needs assessment and staff development plan which provides the knowledge and skills required for staff to maintain competency in their current positions and future advancement.					
	EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and gaps identified.				
		2. A staff development plan based on training needs assessment is available.				
		3. Training schedule/calendar is in place.				
		4. Training module				
	Facility Comments:					
9H.2.2.5	Staff including medical practitioners receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.					
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff including medical practitioner is completed upon probationary period and as an annual exercise.				
	Facility Comments:					
9H.2.2.6	Where appropriate the Facility shall endeavour to undertake clinical research using available resources.					
	EVIDENCE OF COMPLIANCE	1. Documented evidence of research activities, e.g. protocol, policies, consent, research paper, publications, etc.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT															
STANDARD 9H.2.3	<u>STAFFING LEVEL AND STAFF COMPETENCY</u> <i>The Head and staff of the Otorhinolaryngology Service including medical practitioners are individuals qualified by education, training and experience commensurate with the requirements of the various positions and relevant laws.</i>														
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS												
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING											
9H.2.3.1	Deployment of all service providers for Otorhinolaryngology Service takes the following factors into consideration: a) the number of persons deployed is proportional to the number of patients being cared for as in the regulatory requirements and for the intensity of care provided; b) the categories of service providers based on qualifications and experience providing care reflect the complexity of clinical problems being managed; c) staffing needs shall take into consideration absences due to leave or illness; double shift duties by clinical staff shall be documented and monitored; d) adequate staffing levels of appropriate competency shall be maintained throughout the hours the services are in operation. Where services need to be provided on a 24-hour basis, staffing level reflects the intensity of activities during each shift; e) where it is not possible to have service providers on duty on site, e.g. after working hours, provision is made for relevant medical practitioner to be available on call.														
	<table><tr><td rowspan="5">EVIDENCE OF COMPLIANCE</td><td>1. Documentation and planning on deployment of staff that includes but not limited to (a) to (e) with evidence of:</td><td></td></tr><tr><td>a) deployment based on staff to patient ratio, bed occupancy rate and complexity of cases;</td><td></td></tr><tr><td>b) special skills/training of staff;</td><td></td></tr><tr><td>c) contingency plan during acute shortage;</td><td></td></tr><tr><td>d) duty roster.</td><td></td></tr></table>	EVIDENCE OF COMPLIANCE	1. Documentation and planning on deployment of staff that includes but not limited to (a) to (e) with evidence of:		a) deployment based on staff to patient ratio, bed occupancy rate and complexity of cases;		b) special skills/training of staff;		c) contingency plan during acute shortage;		d) duty roster.				
EVIDENCE OF COMPLIANCE	1. Documentation and planning on deployment of staff that includes but not limited to (a) to (e) with evidence of:														
	a) deployment based on staff to patient ratio, bed occupancy rate and complexity of cases;														
	b) special skills/training of staff;														
	c) contingency plan during acute shortage;														
	d) duty roster.														
	Facility Comments:														

SURVEY ITEM & SELF-ASSESSMENT											
STANDARD 9H.2.4	STAFF ORIENTATION <i>A structured orientation programme introduces new staff to their services, operational policies and relevant aspects of the Facility to prepare them for their roles and responsibilities.</i>										
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS								
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING							
9H.2.4.1	There is a structured orientation programme for all newly appointed staff to the Otorhinolaryngology Service including medical practitioners and for those new to specific areas that include the following: a) explanation of the goals, objectives, policies and procedures of the Facility and those of the Otorhinolaryngology Service; b) lines of authority and areas of responsibility; c) explanation of particular duties and functions; d) explanation of the methods of assigning clinical care and the standards of clinical practice; e) handover communication; f) processes for resolving practice dilemmas; g) information about safety procedures; h) training in basic/advanced life support techniques; i) methods of obtaining appropriate resource materials; j) staff appraisal procedures for the Otorhinolaryngology Services; k) education on Patient Centred Care; l) education on MSQH Standards requirements. m) information about care and treatment to limit barriers such as accessibility, languages, spiritual and cultural beliefs etc; n) educate on management of clinical alarm system, Occupational safety and health and fire safety.										
	<table><tr><td rowspan="3">EVIDENCE OF COMPLIANCE</td><td>1. Policy requiring all new staff to attend a structured orientation programme</td><td></td></tr><tr><td>2. There is Surgical Services orientation programme with relevant topics not limited to topics covered from (a) to (l).</td><td></td></tr><tr><td>3. Attendance list</td><td></td></tr></table>	EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme		2. There is Surgical Services orientation programme with relevant topics not limited to topics covered from (a) to (l).		3. Attendance list				
EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme										
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	3. Attendance list										
	Facility Comments:										

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 9H.3:		<u>POLICIES AND PROCEDURES</u>				
STANDARD <u>9H.3.1</u>		<u>DEVELOPMENT, DERIVATION AND DOCUMENTATION</u> <i>There are written and dated policies and procedures for all activities of the Otorhinolaryngology Service. These policies and procedures reflect current standards of medical practice, relevant regulations, statutory requirements, and the purposes of the services. These policies and procedures, terms of reference, by-laws, rules or regulations, state how the clinical staff including medical practitioners regulate themselves and provide patient care.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9H.3.1.1 CORE	There are written policies and procedures for the Otorhinolaryngology Service which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated.					
	There is a mechanism for and evidence of a periodic review at least once in every three years.					
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for the service.				
		2. Policies and procedures are consistent with regulatory requirements and current standard practices.				
		3. Evidence of periodic review of policies and procedures.				
		4. The policies and procedures are endorsed and dated.				
Facility Comments:						
9H.3.1.2	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved. Cross departmental collaboration with Allied Health Services (speech and audiology) is practised in developing relevant policies and procedures where applicable.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.				
		2. Minutes of meeting with evidence of cross reference with other departments				
		3. Documented cross departmental policies				
	Facility Comments:					
9H.3.1.3 CORE	The policies and procedures documentation shall address at least the following topics and any others as required by relevant standards and laws: a) description of the organisational structure and operational policy of the Otorhinolaryngology Service; b) clinical practice guidelines; c) clinical documentation includes pain as the 5 th vital sign where appropriate; d) handover communication; e) drug prescription, dispensing and administration; f) blood transfusion; g) continuing of care including regular review of patient, review of investigation results, discharge (planned or At Own Risk), referrals and escort as necessary; h) pain management; i) management of patients under police custody/prisoner; j) management of cases with an infectious disease including notification of notifiable diseases; k) the responsibilities of the staff including medical practitioners in relation to internal and external disasters are documented, and known to the staff (contingency plan); l) incident reports shall be compiled, investigated, discussed and recorded and action plans implemented; l) end of life care; m) management of a death; n) safe use of optical radiation devices, eg :LASER ; o) sedation policy and procedures; p) management of high risk patients or high risk services – emergency, comatose, immunosuppressive, on life support, on dialysis, with communicable disease, in restraints, receiving chemotherapy, vulnerable patients and palliative care					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	q) Management of patient with implantable medical devices (Hearing aid, Cochlear implant, implantable hearing aid) r) Prescription and procurement of medical devices such as hearing aid and CPAP Machine s) Guidelines on Safe Surgery Saves Lives program.					
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures that address but not limited to items (a) to (t).				
	Facility Comments:					
9H.3.1.4	Current policies and procedures are communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings				
		2. Circulation list and acknowledgement				
	Facility Comments:					
9H.3.1.5 CORE	There is evidence of compliance with policies and procedures.					
	EVIDENCE OF COMPLIANCE	1. Compliance with policies and procedures through:				
		a) interview of staff on practices;				
		b) verify with observation on practices;				
		c) results of audit on practices;				
		d) practices in line with established policies and procedures.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9H.3.1.6	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.					
	EVIDENCE OF COMPLIANCE	1. Copies of relevant policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.				
	Facility Comments:					
9H.3.1.7	The services shall operate on a 24-hour basis providing a level of care appropriate to the activities of the patients in the Facility.					
	EVIDENCE OF COMPLIANCE	1. Operational policy on 24-hour services				
		2. Staffing level reflects good mix of experienced staff and the intensity of activities during each shift.				
		3. On-call roster is dated and authorised.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT							
TOPIC 9H.4: FACILITIES AND EQUIPMENT							
STANDARD 9H.4.1		The Head of Otorhinolaryngology Service shall ensure adequate facilities and equipment that are safe and appropriate are available for the staff to function effectively and to meet the goals and objectives of the Surgical Services.					
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9H.4.1.1	There are adequate and appropriate facilities and equipment with proper utilisation of space to enable staff to carry out their professional, teaching and administrative functions.						
	EVIDENCE OF COMPLIANCE	1. Adequate and proper utilisation of space.					
		2. Appropriate type of equipments to match the complexity of services and subspecialties (emergencies and non emergencies)					
		3. Adequate facilities and equipment at each patient care area for safe care. (e.g. defibrillators, emergency cart, hand washing facilities etc)					
		4. Easy access and clear exit routes					
		5. Absence of overcrowding					
	Facility Comments:						
9H.4.1.2	Existing facilities shall take safety consideration of staffs and patients.						
	EVIDENCE OF COMPLIANCE	1. Design and layout of the unit, e.g. wards, treatment rooms, dirty and clean utility rooms, access, lighting, signage, etc address the safety aspects of patients and staff.					
		2. Adequate equipment and supplies for Otorhinolaryngology Service, e.g. emergency trolley, functioning patient call bell, etc.					
		3. Equipment should have scheduled planned preventive maintenance (PPM).					
	Facility Comments:						

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9H.4.1.3	Suitable and adequate forms of communication and intercommunication systems and equipment are provided to enable clinical staff to communicate among themselves and with the other members of the healthcare team.				
	EVIDENCE OF COMPLIANCE	1. Effective telecommunication modalities available for daily operation and during emergencies.			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT							
STANDARD 9H.4.2	FACILITIES AND EQUIPMENT FOR PATIENT CARE Adequate facilities and equipment shall be available to provide safe and effective patient care.						
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9H.4.2.1	Facilities are suitably located to facilitate easy access and to provide an atmosphere of user, environmental and ‘disabled’ friendly.						
	EVIDENCE OF COMPLIANCE	1. Floor plan indicates accessibility and patient and user friendly.					
		2. Feedback from patient satisfaction survey					
		3. Incident reporting relating to facilities if any					
	Facility Comments:						
9H.4.2.2	Equipment, both for emergency and non-emergency usage, shall be appropriate to the level of care.						
	EVIDENCE OF COMPLIANCE	1. Availability of emergency and non-emergency equipment appropriate to level of care, such as defibrillator, emergency trolley, suction machine, electrocardiogram (ECG) machine, infusion or syringe pump, vital sign monitor, tracheostomy set and tubes, endoscopes, bronchoscopes etc.					
		2. Scheduled checking of items in emergency trolley					
		3. Disinfection procedure/protocol of equipments (scopes , forceps etc)					
		4. dedicated area for dirty and clean procedure					
Facility Comments:							
9H.4.2.3	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.						

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Testing, commissioning and calibration records (certificates or stickers)				
		2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as evidence of compliance to the relevant standards and Acts.				
	Facility Comments:					
9H.4.2.4 CORE	There is evidence that the facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.				CORE – rating should be multiplayer Weightage based on impact on safety	
	EVIDENCE OF COMPLIANCE	1. Planned Preventive Maintenance records such as schedule, stickers, etc.				
		2. Planned Replacement Programme where applicable				
		3. Complaint records				
		4. Asset inventory				
	Facility Comments:					
9H.4.2.5	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.					
	EVIDENCE OF COMPLIANCE	1. User training records				
		2. Competency assessment record				
		3. Letter of authorisation				
		4. List of staff trained and authorised to operate specialised equipment				
	Facility Comments:					
9H.4.2.6	Equipment is upgraded (based on evidence) from time to time so as to keep pace with advancement in operative and diagnostic techniques and technology.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Equipment are being replaced and upgraded to meet current standard of care and advancement in technology in a planned and systematic manner.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT					
STANDARD 9H.4.3	<u>FACILITIES FOR OTORHINOLARYNGOLOGY OUTPATIENT SERVICES</u> <i>Where specialist outpatient services are provided, there are adequate outpatient clinics to enable the provision of safe and effective patient care, and patient privacy and confidentiality are assured.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9H.4.3.1	The Specialist Outpatient Services shall have the following features: a) the organisation and management of the clinics are planned so as to ensure prompt attention to patients, minimal waiting time, and avoidance of unnecessary visits by the patients; b) record keeping shall be efficient; c) an appointment or queuing system is used to manage patient consultations; d) the clinic is easily accessible including for non-ambulant patients and is easily identified through adequate signage; e) the clinic is located easily accessible to other facilities, e.g. radiology, laboratories and pharmacy; f) adequate provision is made for patient comfort.				
	EVIDENCE OF COMPLIANCE	1. The Specialist Outpatient Services address (a) to (f) with evidence of but not limited to the following:			
		a) list of services available and offered to patients;			
		b) flow chart on work process;			
		c) safe keeping of medical records;			
		d) security of data in Health Information System			
		e) clinic appointment system;			
		f) monitoring of waiting time;			
		g) adequate and appropriate signage;			
		h) floor plan indicates accessibility to supporting services and optimisation of space;			
		i) adequate patient personal use items, e.g. wheelchair, etc;			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		j) adequate waiting area, rest rooms, refreshments, reading material and parking space.				
	Facility Comments:					
9H.4.3.2	Adequate numbers of rooms are provided to ensure patient privacy and confidentiality for various patient care activities including: a) consultation (not more than one patient in a room at any time); b) conduct of minor procedures and nursing procedures; maintain a register of procedures performed; c) performance of various tests. d) specified room for audiological testing and speech language therapy sessions. e) Specified room for endoscopy and microscopy procedures.					
	EVIDENCE OF COMPLIANCE	1. Adequate facilities for consultation and patient care activities that address (a) to (c) with evidence of but not limited to the following:				
		a) privacy of patient is ensured;				
		b) procedure room appropriately equipped;				
		c) patient monitoring device is available where required;				
		d) list of procedures done.				
		e) Calibration certification for soundproof room by DOSH (refer to standard 17E)				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 9H.5: SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES						
STANDARD 9H.5.1 <i>The Head of Otorhinolaryngology Service shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Services. The Head of Otorhinolaryngology Service shall ensure compliance to monitoring of specific performance indicators.</i>						
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
9H.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Otorhinolaryngology Services. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.					
	EVIDENCE OF COMPLIANCE				1. Planned performance improvement activities include (a) to (f)	
					2. Records on performance improvement activities	
					3. Minutes of performance improvement meetings	
					4. Performance improvement studies	
					5. Mortality and morbidity audits, POMR reporting status, with remedial actions	
					6. Records on innovation if available.	
					7. Record on the Management of complaints/feedbacks	
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9H.5.1.2	The Head of Otorhinolaryngology Service has assigned the responsibilities for planning, monitoring and managing safety and performance improvement activities to appropriate individual / personnel within the respective services.				
	EVIDENCE OF COMPLIANCE	1. Minutes of meetings			
		2. Letter of assignment of responsibilities			
		3. Job description			
	Facility Comments:				
9H.5.1.3	The Head of Otorhinolaryngology Service shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility.				
	Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.				
	EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:			
		a) Training of staff			
		b) Policy on incident reporting			
		c) Methodology of incident reporting			
		d) Register/records of incidents			
		2. Completed incident reports			
		3. Root Cause Analysis			
		4. Corrective and preventive action plans			
		5. Remedial measure			
		6. Minutes of meetings			
		7. Acknowledgment by Head of Service and PIC/Hospital Director			
		8. Feedback given to staff regarding incident reporting.			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9H.5.1.4 CORE	The staff including medical practitioners provide an appropriate peer group structure for performing the safety and performance improvement activities to accomplish clinical care evaluation.			
	a) The medical practitioners undertake clinical reviews of all risk assessments, incident reports, audits and safety and performance improvement activities: i) as a single committee for all safety and performance improvement activities; ii) in multidisciplinary committees within the service; iii) in a variety of purpose-specific committees, such as mortality and morbidity, infection control, blood transfusion, etc.			
	b) Whatever structure is utilised, provision is made for review and analysis of the clinical work of each individual clinical service, department, unit or function.			
	1. Performance improvement activities			
	2. Minutes of meetings			
	3. Relevant reports and documents, e.g. clinical audit reports, incident reports, mortality and morbidity review reports, etc.			
4. Risk registry/risk management activities				
Facility Comments:				
9H.5.1.5 CORE	There is tracking and trending of specific performance indicators not limited to but at least two (2) of the following: a) number of mortality/morbidity audits/meetings being conducted in the department with documentation of cases discussed b) percentage of unplanned re-admission within 72 hours of discharge c) unplanned return to operating theatre within the same hospital admission following surgery d) ≥ 90% of patients with waiting time of ≤ 90 minutes to see the doctor at Otorhinolaryngology (ORL) Clinic e) Improvement of hearing following myringoplasty ≥ 70% f) Incidence of primary post tonsillectomy haemorrhage ≤ 3%			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored.				
		2. Records on tracking and trending analysis.				
		3. Minutes of mortality/morbidity audits meetings				
		4. Remedial measures taken where appropriate				
	Facility Comments:					
9H.5.1.6	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.					
	EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff.				
		2. Evidence of feedback via communication on results of performance improvement activities through continuing medical education/meetings.				
		3. Minutes of service/unit/committee meetings				
	Facility Comments:					
9H.5.1.7	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.					
	EVIDENCE OF COMPLIANCE	1. Documentation on performance improvement activities and performance indicators.				
		2. Policy statement on anonymity on patients and providers involved in performance improvement activities.				
	Facility Comments:					

SERVICE SUMMARY	
SURVEYOR SUMMARY:	
OVERALL RATING:	
OVERALL RISK:	

SURVEY ITEM & SELF-ASSESSMENT				
SERVICE STANDARD 9I : CLINICAL SERVICES - PSYCHIATRY AND MENTAL HEALTH				
	<u>PREAMBLE</u> <i>Psychiatry Services play an integral role in delivering appropriate care and reducing unwarranted adverse events, as they meet the care people expect to be offered or receive, regardless of where they are treated in the Facility.</i> <i>The Psychiatry Services shall be organised, directed and coordinated with other services in the Facility to provide a high standard of inpatient and outpatient care to the community and cover the following:</i> a) <i>appropriateness of clinical care;</i> b) <i>unwarranted variation in care that is not explained by the clinical circumstances or personal choices of the psychiatry practitioners in:</i> i) <i>overuse of treatments or procedures that do not help patients get better;</i> ii) <i>underuse of care;</i> iii) <i>misuse (or errors) of doing something incorrectly and harming patients.</i> <i>In addition to the above, the Psychiatry Services also conduct teaching and training, research and audit activities where applicable.</i>			
<u>TOPIC 9I.1:</u> <u>STANDARD 9I.1.1</u>	<u>ORGANISATION AND MANAGEMENT</u> <i>The Psychiatry Services shall be organised, directed and coordinated with other services in the Facility to provide a high standard of inpatient and outpatient care to the community in a safe, efficient, effective, evidence based and caring manner and with due regard for the needs, dignity and privacy of patients and confidentiality of their personal information. The Psychiatry Services shall be easily accessible and continuity of care assured.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9I.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Psychiatry Services are clearly documented and measurable that indicates safety, quality and patient centred care. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.					
		2. Goals and objectives of the Psychiatry Services in line with the Facility statements are available, endorsed and dated.					
		3. Evidence of planned reviews of the above statements.					
		4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)					
		5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.					
	Facility Comments:						
91.1.1.2 CORE	There is an organisation chart which: a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head of Psychiatry Services, consultants, psychiatry practitioners and staff of the Psychiatry Services; b) reflect the relevant medical subspecialties services/units; c) is accessible to all staff and clients; d) is revised when there is a major change in any of the following: i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns.						
EVIDENCE OF COMPLIANCE	1. Clearly delineated current organisation chart with line of functions and reporting relationships the Person In Charge (PIC), Head of Psychiatry Services, relevant medical subspecialties services/units, consultants, psychiatry practitioners and staff of the Psychiatry Services.						
	2. Organisation chart of the serviceis endorsed, dated and accessible.						

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).				
	Facility Comments:				
9I.1.1.3	The Governing Body shall ensure that the Psychiatry Services are organised in such a way as to: a) facilitate the provision of Psychiatry Services to patients in the Facility in a safe, efficient, effective, and caring manner and with due regard for the needs, dignity and privacy of patients and confidentiality of their personal information; b) assure continuity of care; c) address the professional needs of the psychiatry practitioners; d) ensure that the psychiatry practitioners are involved in the formulation of policies and procedures concerning patient care appropriate to the scope of services of the Facility.				
	EVIDENCE OF COMPLIANCE	1. Department/Service operational policies that address (a) to (d).			
		2. Medical Staff By-Laws			
		3. Evidence of involvement of psychiatry practitioners in the formulation of policies and procedures concerning patient care.			
		4. Involvement of Head of the Service in the Medical and Dental Advisory Committee/Medical Advisory Committee and ward meetings.			
		5. Minutes of meetings			
		6. Proper and adequate equipment according to current standards.			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9I.1.1.4	There is a mechanism to ensure effective interaction between the Psychiatry Services and the Governing Body on all clinical aspects of healthcare and other relevant matters in the Facility. This mechanism is defined in the policies of the Governing Body and is accomplished through: a) the appointment of a medical practitioner as the Head of Psychiatry Services delineating his/her authority, responsibilities and accountabilities in a written document according to the relevant Acts to manage and control the Psychiatry Services; b) Medical and Dental Advisory Committee (MDAC) to advise the Governing Body on issues related to clinical governance, i.e. in planning, coordinating, implementation, control and to improve activities relating to Psychiatry Services.			
	EVIDENCE OF COMPLIANCE			
	1. Letter of appointment/assignment and delineation of duties and responsibilities of the Head of the Service.			
	2. Letter of appointment and Terms of Reference as member of the Medical and Dental Advisory Committee/Medical Advisory Committee.			
	3. Minutes of meetings of MDAC/Management			
	Facility Comments:			
9I.1.1.5 CORE	The Head of Psychiatry Services has: a) representation of the Service in committees and subcommittees where relevant; b) representation of the Service in clinical staff liaison meetings; c) involvement and provide regular input to the Senior Management Team.			
	EVIDENCE OF COMPLIANCE			
	1. Letter of representation of the Head of Service in committees and subcommittees where relevant, e.g. Blood Transfusion Committee, Medical Records Committee, Hospital Infection and Antibiotic Control Committee, etc.			
	2. Minutes of meetings of committees			
	3. Minutes of meeting of Senior Management Team.			
	Facility Comments:			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9I.1.1.6	The assessment, planning, direction, evaluation and continuity of clinical care are the responsibility of psychiatry practitioners managing individual patients, thus ensuring clinical independence.					
	EVIDENCE OF COMPLIANCE	1. Medical Staff By-Laws; clause indicate clinical care responsibility of psychiatry practitioners.				
		2. Documented evidence of clinical notes in the patient's medical record; e.g. documentation on assessment, planning, direction, evaluation and continuity of clinical care, valid name stamp of medical practitioner.				
	Facility Comments:					
9I.1.1.7	The Head of Psychiatry Services shall be involved for the following aspects of management of the services:					
	a) the preparation of budget and ensuring that expenditure remains within the budget allocated;					
	b) human resource management and development;					
	c) development of policies and procedures and ensuring compliance to them;					
	d) facility and equipment management;					
	e) safety and performance improvement activities and risk management.					
	EVIDENCE OF COMPLIANCE	1. Evidence of (a) to (e) in the minutes of meetings of Psychiatry Services indicate the involvement of Head of Service.				
		2. Endorsement of policies and procedures				
3. Request for allocation of budget and staffing						
4. Implementation of performance improvement activities						
5. Outcoming monitoring and analysing activities						
Facility Comments:						

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9I.1.1.8	Regular staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Psychiatry Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.				
	EVIDENCE OF COMPLIANCE	1. Minutes are accessible, disseminated and acknowledged by the staff.			
		2. Attendance list of members with adequate representatives of the service.			
		3. Frequency of meetings as scheduled.			
		4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).			
		5. Confidentiality and safety of virtual meeting			
	Facility Comments:				
9I.1.1.9	Where there are psychiatry practitioners in training, there is evidence that: a) their responsibilities for patient care are documented; b) their training needs are identified; c) appropriate supervision and training are given to the psychiatry practitioners concerned.				
	EVIDENCE OF COMPLIANCE	1. Structured training programmes for psychiatry practitioners are in place.			
		2. Training timetable, continuing medical education and attendances list			
		3. Assessment reports			
		4. Log books			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9I.1.1.10	Appropriate statistics and records shall be maintained in relation to the provision of Psychiatry Services and used for managing the services and patient care purposes.					
	EVIDENCE OF COMPLIANCE	1. Records are available but not limited to the following:				
		a) workload/census for inpatients and outpatients;				
		b) annual report;				
		c) accident/incident reports;				
		d) staffing number and staff profile;				
		e) staff training records;				
		f) data on performance improvement activities, including performance indicators.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT				
TOPIC 9I.2:		<u>HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT</u>		
STANDARD <u>9I.2.1</u>		<u>CREDENTIALING AND PRIVILEGING</u> <i>The Psychiatry Services shall be directed by a qualified and competent medical practitioner, and staffed by suitably qualified and competent clinical staff to achieve the goals and objectives of the Psychiatry Services.</i>		

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
		4.	Recommendations from peer/referee				
		5.	Availability of the list of procedures requiring credentialing and privileging.				
		6.	Availability of list of procedures to include core procedures specific to the disciplines performed by medical officers; competency records/log books.				
		7.	Privilege for sub specialty for psychiatrist				
		8.	Privileging and credentialing for allied health personal in handling psychiatric patient.				
		9.	Privileging and credentialing in Psychological First Aid				
	Facility Comments:						
91.2.1.2 CORE	Documented evidence of privileges conferred by the Governing Body is available and accessible to relevant staff at point of care.						
	EVIDENCE OF COMPLIANCE	1.	Formal letter of assignment or certificate of privileging with stipulated timeline are issued and reviewed accordingly.				
		2.	Updated list of staff with privileges conferred is made accessible at point of care.				
	Facility Comments:						
91.2.1.3	Clinical staff performs within the privileges conferred.						
	EVIDENCE OF COMPLIANCE	1. Verification of procedures performed by individuals at point of care within the awarded privileging rights with evidence of:					
		a)	list of procedures privileged;				
		b)	clinical notes.				
	Facility Comments:						

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9I.2.1.4	There are written and dated specific job descriptions for all categories of staff that include:			
	a) qualification, training, experience and certification required for the position;			
	b) lines of authority;			
	c) accountability, functions, and responsibilities;			
	d) reviewed when required and when there is a major change in any of the following:			
	i) nature and scope of work;			
	ii) duties and responsibilities;			
EVIDENCE OF COMPLIANCE	iii) general and specific accountabilities;			
	iv) qualifications required and privileges granted;			
	v) staffing patterns;			
	vi) Statutory Regulations.			
	e) administrative and clinical functions.			
	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e).			
	2. Job description includes specialisation skills			
	3. Relevant privileges granted where applicable			
	4. The job description is acknowledged by the staff and signed by the Head of Service and dated.			
	5. Understanding of job description			
	Facility Comments:			

SURVEY ITEM & SELF-ASSESSMENT									
STANDARD 9I.2.2		STAFF TRAINING, EDUCATION, APPRAISAL AND RESEARCH The Facility and all staff shall demonstrate an ongoing commitment to continuing medical education.							
	CRITERIA FOR COMPLIANCE:				SELF RATING	SURVEYOR FINDINGS			
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
9I.2.2.1	There are continuing education activities for staff including psychiatry practitioners to pursue professional interests and to prepare for current and future changes in practice.								
	EVIDENCE OF COMPLIANCE	1. Training calendar includes in-house/external courses/ workshop/conferences							
		2. Contents of training programme							
		3. Objective of training programme							
		4. Training records on continuing education activities are kept and maintained for each staff including training in life support.							
		5. Outcome monitoring / appraisal of the training programme							
		6. Certificate of attendance/degree/post basic training							
	Facility Comments:								
9I.2.2.2	The educational needs of staff and the Facility, as evidenced by the results of medical-care evaluation such as incident reports, performance improvement studies and complaints, are taken into consideration when the content and structure of educational activities are planned.								
	EVIDENCE OF COMPLIANCE	1. Evidence of inclusion of results of audit activities, e.g. mortality and morbidity reviews, incident reporting, etc in educational activities.							
		2. Evidence of improvement made from corrective or preventive measures from incident reports.							
	Facility Comments:								

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9I.2.2.3	In a Facility where undergraduate medical, nursing and allied health training programmes are conducted, the Facility shall ensure there are sufficient skilled trained staff to provide clinical supervision of students.					
	EVIDENCE OF COMPLIANCE	1. Sufficient skilled trained staff to provide clinical supervision as per terms of Memorandum of Understanding.				
	Facility Comments:					
9I.2.2.4	There is evidence of training needs assessment and staff development plan which provide the knowledge and skills required for staff to maintain competency in their current positions and future advancement.					
	EVIDENCE OF COMPLIANCE	1. Assessment of competency				
		2. Training needs assessment is carried out and gaps identified.				
		3. A staff development plan based on training needs assessment is available.				
		4. Training schedule/calendar is in place.				
		5. Training module				
	Facility Comments:					
9I.2.2.5	Staff including psychiatry practitioners receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.					
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff including psychiatry practitioners is completed upon probationary period and as an annual exercise.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9I.2.2.6	Where appropriate the Facility shall endeavor to undertake clinical research using available resources.			
	EVIDENCE OF COMPLIANCE	1. Documented evidence of research and quality activities e.g. protocol, policies, consent etc.		
	Facility Comments:			

SURVEY ITEM &SELF-ASSESSMENT					
STANDARD 9I.2.3		STAFFING LEVEL AND STAFF COMPETENCY The Head and staff of the Psychiatry Services including psychiatry practitioners are individuals qualified by education, training and experience commensurate with the requirements of the various positions and relevant laws.			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9I.2.3.1	Deployment of all service providers for Psychiatry Services takes the following factors into consideration: a) the number of persons deployed is proportional to the number of patients being cared for as in the regulatory requirements and for the intensity of care provided; b) the categories of service providers based on qualifications and experience providing care reflect the complexity of clinical problems being managed; c) staffing needs shall take into consideration absences due to leave or illness; double shift duties by clinical staff shall be documented and monitored; d) adequate staffing levels of appropriate competency shall be maintained throughout the hours the services are in operation. Where services need to be provided on a 24-hourbasis, staffing level reflects the intensity of activities during each shift; e) where it is not possible to have service providers on duty on site, e.g. after working hours, provision is made for relevant medical practitioner to be available on call.				
	EVIDENCE OF COMPLIANCE	1. Documentation and planning on deployment of staff that includes but not limited to (a) to (e) with evidence of:			
		a) deployment based on staff to patient ratio, bed occupancy rate and complexity of cases;			
		b) special skills/training of staff;			
		c) contingency plan during acute shortage;			
		d) duty roster.			
	Facility Comments:				

SURVEY ITEM &SELF-ASSESSMENT											
STANDARD 9I.2.4	<u>STAFF ORIENTATION</u> <i>A structured orientation programme introduces new staff to their services, operational policies and relevant aspects of the Facility to prepare them for their roles and responsibilities.</i>										
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS								
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING							
9I.2.4.1	There is a structured orientation programme for all newly appointed staff to the Psychiatry Services including psychiatry practitioners and for those new to specific areas that include the following: a) explanation of the goals, objectives, policies and procedures of the Facility and those of the Psychiatry Services; b) lines of authority and areas of responsibility; c) explanation of particular duties and functions; d) explanation of the methods of assigning clinical care and the standards of clinical practice; e) handover communication; f) processes for resolving practice dilemmas; g) information about safety procedures; h) training in basic/advanced life support techniques; i) methods of obtaining appropriate resource materials; j) staff appraisal procedures for the Psychiatry Services; k) education on Patient and Family Rights; l) education on MSQH Standards requirements.										
	<table><tr><td rowspan="3">EVIDENCE OF COMPLIANCE</td><td>1. Policy requiring all new staff to attend a structured orientation programme</td><td></td></tr><tr><td>2. There is Psychiatry Services orientation programme with relevant topics not limited to topics covered from (a) to (l).</td><td></td></tr><tr><td>3. Attendance list</td><td></td></tr></table>	EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme		2. There is Psychiatry Services orientation programme with relevant topics not limited to topics covered from (a) to (l).		3. Attendance list				
EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme										
	2. There is Psychiatry Services orientation programme with relevant topics not limited to topics covered from (a) to (l).										
	3. Attendance list										
	Facility Comments:										

SURVEY ITEM & SELF-ASSESSMENT							
<u>TOPIC 9I.3:</u>		<u>POLICIES AND PROCEDURES</u>					
<u>STANDARD</u> <u>9I.3.1</u>		<u>DEVELOPMENT, DERIVATION AND DOCUMENTATION</u> <i>There are written and dated policies and procedures for all activities of the Psychiatry Services. These policies and procedures reflect current standards of medical practice, relevant regulations, statutory requirements, and the purposes of the services. These policies and procedures, terms of reference, by-laws, rules or regulations, state how the clinical staff including psychiatry practitioners regulate themselves and provide patient care.</i>					
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9I.3.1.1 CORE	There are written policies and procedures for the Psychiatry Services which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated.						
	There is a mechanism for and evidence of a periodic review at least once in every three years.						
	EVIDENCE OF COMPLIANCE	1.	Documented policies and procedures for the service.				
		2.	Policies and procedures are consistent with regulatory requirements and current standard practices.				
		3.	Evidence of periodic review of policies and procedures.				
		4.	The policies and procedures are endorsed and dated.				
Facility Comments:							
9I.3.1.2	Policies and procedures are developed by a committee in collaboration with staff, psychiatry practitioners, Management and where required with other external service providers and with reference to relevant sources involved.						
Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.							

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.				
		2. Minutes of meeting with evidence of cross reference with other departments				
		3. Documented cross departmental policies				
	Facility Comments:					
91.3.1.3 CORE	The policies and procedures documentation shall address at least the following topics and any others as required by relevant standards and laws: a) description of the organisational structure of the Psychiatry Services; b) clinical practice guidelines; c) clinical documentation includes pain as the 5 th vital sign where appropriate; d) handover communication; e) drug prescription, dispensing and administration; f) blood transfusion; g) continuing of care including regular review of patient, review of investigation results, discharge (planned or At Own Risk), referrals and escort as necessary; h) pain management; i) management of patients under police custody/prisoner; j) management of cases with an infectious disease including notification of notifiable diseases; k) the responsibilities of the staff including psychiatry practitioners in relation to internal and external disasters are documented, and known to the staff (contingency plan); l) incident reports shall be compiled, investigated, discussed and recorded and action plans implemented; m) end of life care; n) management of a death.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures that address but not limited to (a) to (n).				
	Facility Comments:					
91.3.1.4	Current policies and procedures are communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/ Minutes of meetings				
		2. Circulation list, acknowledgement and understanding				
	Facility Comments:					
91.3.1.5 CORE	There is evidence of compliance with policies and procedures.					
	EVIDENCE OF COMPLIANCE	1.Compliance with policies and procedures through:				
		a) interview of staff on practices;				
		b) verify with observation on practices;				
		c) results of audit on practices;				
		d) practices in line with established policies and procedures.				
	Facility Comments:					
91.3.1.6	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Copies of relevant policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.				
	Facility Comments:					
91.3.1.7	The services shall operate on a 24-hour basis providing a level of care appropriate to the activities of the patients in the Facility.					
	EVIDENCE OF COMPLIANCE	1. Operational policy on 24-hour services				
		2. Staffing level reflects good mix of experienced staff and the intensity of activities during each shift.				
		3. On-call roster is dated and authorised.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT					
TOPIC 9I.4:	<u>FACILITIES AND EQUIPMENT</u>				
STANDARD 9I.4.1	<i>The Head of Psychiatry Services shall ensure adequate facilities and equipment that are safe and appropriate are available for the staff to function effectively and to meet the goals and objectives of the Psychiatry Services.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9I.4.1.1	There are adequate and appropriate facilities and equipment with proper utilisation of space to enable staff to carry out their professional, teaching and administrative functions.				
	EVIDENCE OF COMPLIANCE	1. Adequate and proper utilisation of space.			
		2. Appropriate type of equipment to match the complexity of services.			
		3. Adequate facilities and equipment at each patient care area for safe care. (e.g. defibrillators, emergency cart, hand washing facilities, no hanging point etc)			
		4. Easy access and clear exit routes			
		5. Absence of overcrowding			
		6. Contingency plan			
	Facility Comments:				
9I.4.1.2	Existing facilities shall take cognisance of the safety of staff and patients.				
	EVIDENCE OF COMPLIANCE	1. Design and layout of the unit, e.g. wards, treatment rooms, dirty and clean utility rooms, access, lighting, signage, etc address the safety aspects of patients and staff.			
		2. Adequate equipment and supplies for Psychiatry Services, e.g. emergency trolley, functioning patient call bell, etc.			
		3. Equipment should have scheduled planned preventive maintenance (PPM).			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9I.4.1.3	Suitable and adequate forms of communication and intercommunication systems and equipment are provided to enable clinical staff to communicate among themselves and with the other members of the healthcare team.					
	EVIDENCE OF COMPLIANCE	1. Appropriate telecommunication modalities available for daily operation and during emergencies.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT								
STANDARD 9I.4.2	FACILITIES AND EQUIPMENT FOR PATIENT CARE Adequate facilities and equipment shall be available to provide safe and effective patient care.							
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
9I.4.2.1	Facilities are suitably located to facilitate easy access and to provide an atmosphere of user, environmental and ‘disabled’ friendly.							
	EVIDENCE OF COMPLIANCE	1. Floor plan indicates accessibility and patient and user friendly.						
		2. Feedback from patient satisfaction survey						
		3. Incident reporting relating to facilities if any.						
	Facility Comments:							
9I.4.2.2	Equipment, both for emergency and non-emergency usage, shall be appropriate to the level of care.							
	EVIDENCE OF COMPLIANCE	1. Availability of emergency and non-emergency equipment appropriate to level of care, such as defibrillator, emergency trolley, suction machine, electrocardiogram (ECG) machine, infusion or syringe pump, vital sign monitor, etc.						
		2. Scheduled checking of items in emergency trolley.						
	Facility Comments:							
9I.4.2.3	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.							
	EVIDENCE OF COMPLIANCE	1. Testing, commissioning and calibration records (certificates or stickers).						
		2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as evidence of compliance to the relevant standards and Acts.						
	Facility Comments:							

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
91.4.2.4 CORE	There is evidence that the facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.				
	EVIDENCE OF COMPLIANCE	1. Planned Preventive Maintenance records such as schedule, stickers, etc.			
		2. Planned Replacement Programme where applicable			
		3. Complaint records			
		4. Asset inventory			
	Facility Comments:				
91.4.2.5	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.				
	EVIDENCE OF COMPLIANCE	1. User training records			
		2. Competency assessment record			
		3. Letter of authorisation			
		4. List of staff trained and authorised to operate specialised equipment			
	Facility Comments:				
91.4.2.6	Equipment is upgraded (based on evidence) from time to time so as to keep pace with advancement in operative and diagnostic techniques and technology.				
	EVIDENCE OF COMPLIANCE	1. Equipment are being replaced and upgraded to meet current standard of care and advancement in technology in a planned and systematic manner.			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT						
STANDARD 9I.4.3		FACILITIES FOR PSYCHIATRY RELATED OUTPATIENT SERVICES Where specialist outpatient services are provided, there are adequate outpatient clinics to enable the provision of safe and effective patient care; and patient privacy and confidentiality are assured.				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9I.4.3.1	The Specialist Outpatient Services shall have the following features:					
	a) the organisation and management of the clinics are planned so as to ensure prompt attention to patients, minimal waiting time, and avoidance of unnecessary visits by the patients;					
	b) record keeping shall be efficient;					
	c) an appointment or queuing system is used to manage patient consultations;					
	d) the clinic is easily accessible including for non-ambulant patients and is easily identified through adequate signage;					
	e) the clinic is located close to other facilities, e.g. radiology, laboratories and pharmacy;					
	f) adequate provision is made for patient comfort.					
	EVIDENCE OF COMPLIANCE	1. The Specialist Outpatient Services address (a) to (f) with evidence of but not limited to the following:				
		a) list of services available and offered to patients;				
		b) flow chart on work process;				
		c) safe keeping of PS records;				
d) security of data in Health Information System;						
e) clinic appointment system;						
f) monitoring of waiting time;						
g) adequate and appropriate signage;						
h) floor plan indicates accessibility to supporting services and optimisation of space;						
i) adequate patient personal use items, e.g. wheelchair, etc;						

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		j) adequate waiting area, rest rooms, refreshments, reading material and parking space.				
	Facility Comments:					
9I.4.3.2	Adequate numbers of rooms are provided to ensure patient privacy and confidentiality for various patient care activities including: a) consultation (not more than one patient in a room at any time); b) conduct of minor procedures and nursing procedures; maintain a register of procedures performed; c) performance of various tests.					
	EVIDENCE OF COMPLIANCE	1. Adequate facilities for consultation and patient care activities that address (a) to (c) with evidence of but not limited to the following:				
		a) privacy of patient is ensured;				
		b) procedure room appropriately equipped;				
		c) patient monitoring device is available where required;				
		d) list of procedures done.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
<u>TOPIC 9I.5:</u>	<u>SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES</u>					
<u>STANDARD 9I.5.1</u>	<i>The Head of Psychiatry Services shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Psychiatry Services. The Head of Psychiatry Services shall ensure compliance to monitoring of specific performance indicators.</i>					
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
9I.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Psychiatry Services. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.					
	EVIDENCE OF COMPLIANCE				1. Planned performance improvement activities include (a) to (f)	
					2. Records on performance improvement activities	
					3. Minutes of performance improvement meetings	
					4. Performance improvement studies	
					5. Mortality and morbidity audits with remedial actions	
					6. Records on innovation if available.	
	Facility Comments:					
9I.5.1.2	The Head of Psychiatry Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement activities to appropriate individual/ personnel within the respective services.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes of meetings				
		2. Letter of assignment of responsibilities				
		3. Job description				
		Facility Comments:				
91.5.1.3	The Head of Psychiatry Services shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility. Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.					
	EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:				
		a) Training of staff				
		b) Policy on incident reporting				
		c) Methodology of incident reporting				
		d) Register/records of incidents				
		2. Completed incident reports				
		3. Root Cause Analysis				
		4. Corrective and preventive action plans				
		5. Remedial measure				
		6. Minutes of meetings				
		7. Acknowledgment by Head of Service and PIC/Hospital Director				
		8. Feedback given to staff regarding incident reporting.				
		Facility Comments:				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9I.5.1.4 CORE	The staff including psychiatry practitioners provide an appropriate peer group structure for performing the safety and performance improvement activities to accomplish clinical care evaluation.			
	a) The psychiatry practitioners undertake clinical reviews of all risk assessments, incident reports, audits and safety and performance improvement activities:			
	i) as a single committee for all safety and performance improvement activities;			
	ii) in multidisciplinary committees within the service;			
	iii) in a variety of purpose-specific committees, such as mortality and morbidity, infection control, blood transfusion, etc.			
	b) Whatever structure is utilised, provision is made for review and analysis of the clinical work of each individual clinical service, department, unit or function.			
EVIDENCE OF COMPLIANCE	1. Performance improvement activities			
	2. Minutes of meetings			
	3. Relevant reports and documents, e.g. clinical audit reports, incident reports, mortality and morbidity review reports, etc.			
Facility Comments:				
9I.5.1.5 CORE	There is tracking and trending of specific performance indicators not limited to but at least two (2) of the following:			
	a) number of mortality/morbidity audits/meetings being conducted in the department with documentation of cases discussed			
	b) percentage of unplanned re-admission within 72 hours of discharge			
Subspecialties units in the Psychiatry Services				
Subspecialties units in the Psychiatry Services, e.g. Respiratory Medicine, Gastroenterology, Nephrology, Rheumatology, etc shall monitor any other two (2) indicators to support its goals and objectives.				
	1. Specific performance indicators monitored.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	2. Records on tracking and trending analysis.				
		3. Minutes of mortality/morbidity audits meetings				
		4. Remedial measures taken where appropriate				
	Facility Comments:					
9I.5.1.6	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.					
	EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff.				
		2. Evidence of feedback via communication on results of performance improvement activities through continuing medical education/meetings.				
		3. Minutes of service/unit/committee meetings				
	Facility Comments:					
9I.5.1.7	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of psychiatry practitioners, staff and patients is preserved.					
	EVIDENCE OF COMPLIANCE	1. Documentation on performance improvement activities and performance indicators.				
		2. Policy statement on anonymity on patients and providers involved in performance improvement activities.				
	Facility Comments:					

SURVEYOR SUMMARY:

OVERALL RISK:

SURVEY ITEM & SELF-ASSESSMENT				
SERVICE STANDARD 9J : CLINICAL SERVICES - ORTHOPAEDICS				
	<u>PREAMBLE</u> <i>Surgical Services play an integral role in delivering appropriate care and reducing unwarranted adverse events, as they meet the care people expect to be offered or receive, regardless of where they are treated in the Facility.</i> <i>The Surgical Services shall be organised, directed and coordinated with other services in the Facility to provide a high standard of inpatient and outpatient care to the community and cover the following:</i> <i>a) appropriateness of clinical care;</i> <i>b) unwarranted variation in care that is not explained by the clinical circumstances or personal choices of the medical practitioners in:-</i> <i>i) overuse of treatments or procedures that do not help patients get better;</i> <i>ii) underuse of care;</i> <i>iii) misuse (or errors) of doing something incorrectly and harming patients.</i> <i>In addition to the above, the Surgical Services also conduct teaching and training, research and audit activities where applicable.</i>			
<u>TOPIC 9J.1:</u> <u>STANDARD 9J.1.1</u>	<u>ORGANISATION AND MANAGEMENT</u> <i>The Surgical Services shall be organised, directed and coordinated with other services in the Facility to provide a high standard of inpatient and outpatient care to the community in a safe, efficient, effective, evidence based and caring manner and with due regard for the needs, dignity and privacy of patients and confidentiality of their personal information. The Surgical Services shall be easily accessible and continuity of care assured.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9J.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Surgical Services are clearly documented and measurable that indicates safety, quality and patient centred care. These reflect the roles and aspirations of the service and the needs of the community. These statements			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	are monitored, reviewed and revised as required accordingly and communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.				
		2. Goals and objectives of the Surgical Services in line with the Facility statements are available, endorsed and dated.				
		3. Evidence of planned reviews of the above statements.				
		4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)				
		5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.				
	Facility Comments:					
9J.1.1.2 CORE	There is an organisation chart which: a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head of Surgical Services, consultants, medical practitioners and staff of the Surgical Services; b) reflect the relevant surgical subspecialties services/units; c) is accessible to all staff and clients; d) is revised when there is a major change in any of the following: i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns.					
EVIDENCE OF COMPLIANCE	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head of Surgical Services, relevant surgical subspecialties services/units, consultants, medical practitioners and staff of the Surgical Services.					
	2. Organisation chart of the service is endorsed, dated and accessible.					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).				
	Facility Comments:				
9J.1.1.3	The Governing Body shall ensure that Surgical Services are organised in such a way as to: a) facilitate the provision of surgical services to patients in the Facility in a safe, efficient, effective, and caring manner and with due regard for the needs, dignity and privacy of patients and confidentiality of their personal information; b) assure continuity of care; c) address the professional needs of the medical practitioners; d) ensure that the medical practitioners are involved in the formulation of policies and procedures concerning patient care appropriate to the scope of services of the Facility.				
	EVIDENCE OF COMPLIANCE 1. Departmental/Service operational policies that address (a) to (d). 2. Medical Staff By-Laws 3. Evidence of involvement of medical practitioners in the formulation of policies and procedures concerning patient care. 4. Involvement of Head of the Service in the Medical and Dental Advisory Committee/Medical Advisory Committee and ward meetings. 5. Minutes of meetings 6. Proper and adequate equipment according to current standards.				
	Facility Comments:				
9J.1.1.4	There is a mechanism to ensure effective interaction between the Surgical Services and the Governing Body on all clinical aspects of healthcare and other relevant matters in the Facility. This mechanism is defined in the policies of the Governing Body and is accomplished through:				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	a) the appointment of a medical practitioner as the Head of Surgical Services delineating his/her authority, responsibilities and accountabilities in a written document according to the relevant Acts to manage and control the Surgical Services;					
	b) Medical and Dental Advisory Committee (MDAC) to advise the Governing Body on issues related to clinical governance, i.e. in planning, coordinating, implementation, control and to improve activities relating to Surgical Services.					
	EVIDENCE OF COMPLIANCE				1. Letter of appointment/assignment and delineation of duties and responsibilities of the Head of the Service.	
	2. Letter of appointment and Terms of Reference as member of the Medical and Dental Advisory Committee/Medical Advisory Committee.					
	3. Minutes of meetings of MDAC/Management					
	Facility Comments:					
9J.1.1.5 CORE	The Head of Surgical Services has:					
	a) representation of the Service in committees and subcommittees where relevant;					
	b) representation of the Service in clinical staff liaison meetings;					
	c) involvement and provide regular input to the Senior Management Team.					
	EVIDENCE OF COMPLIANCE				1. Letter of representation of the Head of Service in committees and subcommittees where relevant, e.g.Blood Transfusion Committee, Medical Records Committee, Hospital Infection and Antibiotic Control Committee, etc.	
	2. Minutes of meetings of committees					
3. Minutes of meeting of Senior Management Team.						
Facility Comments:						

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9J.1.1.6	The assessment, planning, direction, evaluation and continuity of clinical care are the responsibility of medical practitioners managing individual patients, thus ensuring clinical independence.					
	EVIDENCE OF COMPLIANCE	1. Medical Staff By-Laws; clause indicate clinical care responsibility of medical practitioners.				
		2. Documented evidence of clinical notes in the patient's medical record; e.g. documentation on assessment, planning, direction, evaluation and continuity of clinical care, valid name stamp of medical practitioner.				
	Facility Comments:					
9J.1.1.7	The Head of Surgical Services shall be involved for the following aspects of management of the services: a) the preparation of budget and ensuring that expenditure remains within the budget allocated; b) human resource management and development; c) development of policies and procedures and ensuring compliance to them; d) facility and equipment management; e) safety and performance improvement activities and risk management.					
	EVIDENCE OF COMPLIANCE	1. Evidence of (a) to (e) in the minutes of meetings of Surgical Services indicate the involvement of Head of Service.				
		2. Endorsement of policies and procedures				
		3. Request for allocation of budget and staffing				
		4. Implementation of performance improvement activities				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9J.1.1.8	Regular staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Surgical Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.				
	EVIDENCE OF COMPLIANCE	1. Minutes are accessible, disseminated and acknowledged by the staff.			
		2. Attendance list of members with adequate representatives of the service.			
		3. Frequency of meetings as scheduled.			
		4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).			
	Facility Comments:				
9J.1.1.9	Where there are medical practitioners in training, there is evidence that: a) their responsibilities for patient care are documented; b) their training needs are identified; c) appropriate supervision and training are given to the medical practitioners concerned.				
	EVIDENCE OF COMPLIANCE	1. Structured training programmes for medical practitioners are in place.			
		2. Training timetable, continuing medical education and attendances list			
		3. Assessment reports			
		4. Log books			
	Facility Comments:				
9J.1.1.10	Appropriate statistics and records shall be maintained in relation to the provision of Surgical Services and used for managing the services and patient care purposes.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Records are available but not limited to the following:				
		a) workload/census for inpatients and outpatients;				
		b) annual report;				
		c) accident/incident reports;				
		d) staffing number and staff profile;				
		e) staff training records;				
	f) data on performance improvement activities, including performance indicators.					
Facility Comments:						

SURVEY ITEM & SELF-ASSESSMENT				
TOPIC 9J.2:	<u>HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT</u>			
STANDARD 9J.2.1	<u>CREDENTIALING AND PRIVILEGING</u> <i>The Surgical Services shall be directed by a qualified and competent medical practitioner, and staffed by suitably qualified and competent clinical staff to achieve the goals and objectives of the Surgical Services.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9J.2.1.1 CORE	There is documented evidence of appropriate training and competency for the granting of clinical privileging. The criteria for determining privileges are specified and documented. There is a structured process to ensure the stated criteria are uniformly applied to all applicants. These include:			
	a) the criteria are designed to assure that patients will receive safe and quality care; b) the criteria for individual procedures are documented in detail; e.g. competency records/log books, application from the individual practitioner, recommendations from peer/referee and minutes of meeting; c) competency for each performance is dated, verified and signed by the supervisors; d) the period of time for which the privileges are to be granted is specified; e) current registration with the local professional registration bodies, e.g. Malaysian Medical Council, National Specialist Register (NSR); f) peer recommendations are taken into account when privileges are being considered; g) the recommendations of the relevant department and/or major professional services for privileges to be granted are taken into consideration.			
	1. Documented policies and procedures are established to govern the credentialing and privileging processes which include items (a) to (g).			
	2. Compliance with policy and criteria for credentialing and privileging			
	3. Annual Practising Certificate (APC), National Specialist Register (NSR) certificate and privileging certificate.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		4. Recommendations from peer/referee				
		5. Availability of the list of procedures requiring credentialing and privileging.				
		6. Availability of list of procedures to include core procedures specific to the disciplines performed by medical officers; competency records/log books.				
	Facility Comments:					
9J.2.1.2 CORE	Documented evidence of privileges conferred by the Governing Body is available and accessible to relevant staff at point of care.					
	EVIDENCE OF COMPLIANCE	1. Formal letter of assignment or certificate of privileging with stipulated timeline are issued and reviewed accordingly.				
		2. Updated list of staff with privileges conferred is made accessible at point of care.				
	Facility Comments:					
9J.2.1.3	Clinical staff performs within the privileges conferred.					
	EVIDENCE OF COMPLIANCE	1. Verification of procedures performed by individuals at point of care within the awarded privileging rights with evidence of:				
		a) list of procedures privileged;				
		b) operating list;				
		c) operating notes/clinical notes.				
	Facility Comments:					
9J.2.1.4	There are written and dated specific job descriptions for all categories of staff that include:					
	a) qualification, training, experience and certification required for the position;					
	b) lines of authority;					
	c) accountability, functions, and responsibilities;					
	d) reviewed when required and when there is a major change in any of the following:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations.					
	e) administrative and clinical functions.					
	EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e).				
		2. Job description includes specialisation skills				
		3. Relevant privileges granted where applicable				
		4. The job description is acknowledged by the staff and signed by the Head of Service and dated.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT								
STANDARD 9J.2.2	STAFF TRAINING, EDUCATION, APPRAISAL AND RESEARCH The Facility and all staff shall demonstrate an ongoing commitment to continuing medical education.							
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
9J.2.2.1	There are continuing education activities for staff including medical practitioners to pursue professional interests and to prepare for current and future changes in practice.							
	EVIDENCE OF COMPLIANCE	1. Training calendar includes in-house/external courses/ workshop/conferences						
		2. Contents of training programme						
		3. Training records on continuing education activities are kept and maintained for each staff including training in life support.						
		4. Certificate of attendance/degree/post basic training						
	Facility Comments:							
9J.2.2.2	The educational needs of staff and the Facility, as evidenced by the results of medical-care evaluation such as incident reports, performance improvement studies and complaints, are taken into consideration when the content and structure of educational activities are planned.							
	EVIDENCE OF COMPLIANCE	1. Evidence of inclusion of results of audit activities, e.g. mortality and morbidity reviews, incident reporting, etc in educational activities.						
		2. Evidence of improvement made from corrective or preventive measures from incident reports.						
	Facility Comments:							
9J.2.2.3	In a Facility where undergraduate medical, nursing and allied health training programmes are conducted, the Facility shall ensure that there are sufficient skilled trained staff to provide clinical supervision of students.							

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Sufficient skilled trained staff to provide clinical supervision as per terms of Memorandum of Understanding.				
	Facility Comments:					
9J.2.2.4	There is evidence of training needs assessment and staff development plan which provides the knowledge and skills required for staff to maintain competency in their current positions and future advancement.					
	EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and gaps identified.				
		2. A staff development plan based on training needs assessment is available.				
		3. Training schedule/calendar is in place.				
		4. Training module				
	Facility Comments:					
9J.2.2.5	Staff including medical practitioners receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.					
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff including medical practitioner is completed upon probationary period and as an annual exercise.				
	Facility Comments:					
9J.2.2.6	Where appropriate the Facility shall endeavour to undertake clinical research using available resources.					
	EVIDENCE OF COMPLIANCE	1. Documented evidence of research activities, e.g. protocol, policies, consent, etc.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT					
STANDARD 9J.2.3		<u>STAFFING LEVEL AND STAFF COMPETENCY</u> <i>The Head and staff of the Surgical Services including medical practitioners are individuals qualified by education, training and experience commensurate with the requirements of the various positions and relevant laws.</i>			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9J.2.3.1	Deployment of all service providers for Surgical Services takes the following factors into consideration: a) the number of persons deployed is proportional to the number of patients being cared for as in the regulatory requirements and for the intensity of care provided; b) the categories of service providers based on qualifications and experience providing care reflect the complexity of clinical problems being managed; c) staffing needs shall take into consideration absences due to leave or illness; double shift duties by clinical staff shall be documented and monitored; d) adequate staffing levels of appropriate competency shall be maintained throughout the hours the services are in operation. Where services need to be provided on a 24-hour basis, staffing level reflects the intensity of activities during each shift; e) where it is not possible to have service providers on duty on site, e.g. after working hours, provision is made for relevant medical practitioner to be available on call.				
	EVIDENCE OF COMPLIANCE	1. Documentation and planning on deployment of staff that includes but not limited to (a) to (e) with evidence of:			
		a) deployment based on staff to patient ratio, bed occupancy rate and complexity of cases;			
		b) special skills/training of staff;			
		c) contingency plan during acute shortage;			
		d) duty roster.			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT											
STANDARD 9J.2.4	STAFF ORIENTATION <i>A structured orientation programme introduces new staff to their services, operational policies and relevant aspects of the Facility to prepare them for their roles and responsibilities.</i>										
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS								
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING							
9J.2.4.1	There is a structured orientation programme for all newly appointed staff to the Surgical Services including medical practitioners and for those new to specific areas that include the following: a) explanation of the goals, objectives, policies and procedures of the Facility and those of the Surgical Services; b) lines of authority and areas of responsibility; c) explanation of particular duties and functions; d) explanation of the methods of assigning clinical care and the standards of clinical practice; e) handover communication; f) processes for resolving practice dilemmas; g) information about safety procedures; h) training in basic/advanced life support techniques; i) methods of obtaining appropriate resource materials; j) staff appraisal procedures for the Surgical Services; k) education on Patient and Family Rights; l) education on MSQH Standards requirements.										
	<table border="1"> <tr> <td rowspan="3">EVIDENCE OF COMPLIANCE</td> <td>1. Policy requiring all new staff to attend a structured orientation programme</td> <td></td> </tr> <tr> <td>2. There is Surgical Services orientation programme with relevant topics not limited to topics covered from (a) to (l).</td> <td></td> </tr> <tr> <td>3. Attendance list</td> <td></td> </tr> </table>	EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme		2. There is Surgical Services orientation programme with relevant topics not limited to topics covered from (a) to (l).		3. Attendance list				
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	Facility Comments:										

SURVEY ITEM & SELF-ASSESSMENT				
TOPIC 9J.3:		<u>POLICIES AND PROCEDURES</u>		
STANDARD		<u>DEVELOPMENT, DERIVATION AND DOCUMENTATION</u>		
9J.3.1		<i>There are written and dated policies and procedures for all activities of the Surgical Services. These policies and procedures reflect current standards of medical practice, relevant regulations, statutory requirements, and the purposes of the services. These policies and procedures, terms of reference, by-laws, rules or regulations, state how the clinical staff including medical practitioners regulate themselves and provide patient care.</i>		

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9J.3.1.3 CORE	The policies and procedures documentation shall address at least the following topics and any others as required by relevant standards and laws: a) description of the organisational structure of the Surgical Services; b) clinical practice guidelines; c) clinical documentation includes pain as the 5 th vital sign where appropriate; d) handover communication; e) drug prescription, dispensing and administration; f) blood transfusion; g) continuing of care including regular review of patient, review of investigation results, discharge (planned or At Own Risk), referrals and escort as necessary; h) pain management; i) management of patients under police custody/prisoner; j) management of cases with an infectious disease including notification of notifiable diseases; k) the responsibilities of the staff including medical practitioners in relation to internal and external disasters are documented, and known to the staff (contingency plan); n) incident reports shall be compiled, investigated, discussed and recorded and action plans implemented; l) end of life care; m) management of a death.				
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures that address but not limited to items (a) to (n).			
	Facility Comments:				
9J.3.1.4	Current policies and procedures are communicated to all staff.				
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings			
		2. Circulation list and acknowledgement			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9J.3.1.5 CORE	There is evidence of compliance with policies and procedures.					
	EVIDENCE OF COMPLIANCE	1. Compliance with policies and procedures through:				
		a) interview of staff on practices;				
		b) verify with observation on practices;				
		c) results of audit on practices;				
		d) practices in line with established policies and procedures.				
	Facility Comments:					
9J.3.1.6	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.					
	EVIDENCE OF COMPLIANCE	1. Copies of relevant policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.				
Facility Comments:						
9J.3.1.7	The services shall operate on a 24-hour basis providing a level of care appropriate to the activities of the patients in the Facility.					
	EVIDENCE OF COMPLIANCE	1. Operational policy on 24-hour services				
		2. Staffing level reflects good mix of experienced staff and the intensity of activities during each shift.				
		3. On-call roster is dated and authorised.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 9J.4: FACILITIES AND EQUIPMENT						
STANDARD 9J.4.1 <i>The Head of Surgical Services shall ensure adequate facilities and equipment that are safe and appropriate are available for the staff to function effectively and to meet the goals and objectives of the Surgical Services.</i>						
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9J.4.1.1	There are adequate and appropriate facilities and equipment with proper utilisation of space to enable staff to carry out their professional, teaching and administrative functions.					
	EVIDENCE OF COMPLIANCE	1. Adequate and proper utilisation of space.				
		2. Appropriate type of equipment to match the complexity of services.				
		3. Adequate facilities and equipment at each patient care area for safe care. (e.g. defibrillators, emergency cart, hand washing facilities etc)				
		4. Easy access and clear exit routes				
		5. Absence of overcrowding				
	Facility Comments:					
9J.4.1.2	Existing facilities shall take cognisance of the safety of staff and patients.					
	EVIDENCE OF COMPLIANCE	1. Design and layout of the unit, e.g. wards, treatment rooms, dirty and clean utility rooms, access, lighting, signage, etc address the safety aspects of patients and staff.				
		2. Adequate equipment and supplies for Surgical Services, e.g. emergency trolley, functioning patient call bell, etc.				
		3. Equipment should have scheduled planned preventive maintenance (PPM).				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9J.4.1.3	Suitable and adequate forms of communication and intercommunication systems and equipment are provided to enable clinical staff to communicate among themselves and with the other members of the healthcare team.				
	EVIDENCE OF COMPLIANCE	1. Appropriate telecommunication modalities available for daily operation and during emergencies.			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT								
STANDARD 9J.4.2	<u>FACILITIES AND EQUIPMENT FOR PATIENT CARE</u> <i>Adequate facilities and equipment shall be available to provide safe and effective patient care.</i>							
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
9J.4.2.1	Facilities are suitably located to facilitate easy access and to provide an atmosphere of user, environmental and 'disabled' friendly.							
	EVIDENCE OF COMPLIANCE	1. Floor plan indicates accessibility and patient and user friendly.						
		2. Feedback from patient satisfaction survey						
		3. Incident reporting relating to facilities if any						
	Facility Comments:							
9J.4.2.2	Equipment, both for emergency and non-emergency usage, shall be appropriate to the level of care.							
	EVIDENCE OF COMPLIANCE	1. Availability of emergency and non-emergency equipment appropriate to level of care, such as defibrillator, emergency trolley, suction machine, electrocardiogram (ECG) machine, infusion or syringe pump, vital sign monitor, etc.						
		2. Scheduled checking of items in emergency trolley						
	Facility Comments:							
9J.4.2.3	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.							
	EVIDENCE OF COMPLIANCE	1. Testing, commissioning and calibration records (certificates or stickers)						
		2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as evidence of compliance to the relevant standards and Acts.						

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	Facility Comments:				
9J.4.2.4 CORE	There is evidence that the facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.				
	EVIDENCE OF COMPLIANCE	1. Planned Preventive Maintenance records such as schedule, stickers, etc.			
		2. Planned Replacement Programme where applicable			
		3. Complaint records			
		4. Asset inventory			
	Facility Comments:				
9J.4.2.5	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.				
	EVIDENCE OF COMPLIANCE	1. User training records			
		2. Competency assessment record			
		3. Letter of authorisation			
		4. List of staff trained and authorised to operate specialised equipment			
	Facility Comments:				
9J.4.2.6	Equipment is upgraded (based on evidence) from time to time so as to keep pace with advancement in operative and diagnostic techniques and technology.				
	EVIDENCE OF COMPLIANCE	1. Equipment are being replaced and upgraded to meet current standard of care and advancement in technology in a planned and systematic manner.			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT						
STANDARD 9J.4.3	<i>FACILITIES FOR SURGICAL RELATED OUTPATIENT SERVICES</i> <i>Where specialist outpatient services are provided, there are adequate outpatient clinics to enable the provision of safe and effective patient care; and patient privacy and confidentiality are assured.</i>					
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9J.4.3.1	The Specialist Outpatient Services shall have the following features:					
	a) the organisation and management of the clinics are planned so as to ensure prompt attention to patients, minimal waiting time, and avoidance of unnecessary visits by the patients;					
	b) record keeping shall be efficient;					
	c) an appointment or queuing system is used to manage patient consultations;					
	d) the clinic is easily accessible including for non-ambulant patients and is easily identified through adequate signage;					
	e) the clinic is located close to other facilities, e.g. radiology, laboratories and pharmacy;					
	f) adequate provision is made for patient comfort.					
	EVIDENCE OF COMPLIANCE	1. The Specialist Outpatient Services address (a) to (f) with evidence of but not limited to the following:				
		a) list of services available and offered to patients;				
		b) flow chart on work process;				
		c) safe keeping of medical records;				
		d) security of data in Health Information System				
		e) clinic appointment system;				
f) monitoring of waiting time;						
g) adequate and appropriate signage;						
h) floor plan indicates accessibility to supporting services and optimisation of space;						
i) adequate patient personal use items, e.g. wheelchair, etc;						

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		j) adequate waiting area, rest rooms, refreshments, reading material and parking space.				
	Facility Comments:					
9J.4.3.2	Adequate numbers of rooms are provided to ensure patient privacy and confidentiality for various patient care activities including:					
	a) consultation (not more than one patient in a room at any time);					
	b) conduct of minor procedures and nursing procedures; maintain a register of procedures performed;					
	c) performance of various tests.					
	EVIDENCE OF COMPLIANCE	1. Adequate facilities for consultation and patient care activities that address (a) to (c) with evidence of but not limited to the following:				
		a) privacy of patient is ensured;				
		b) procedure room appropriately equipped;				
		c) patient monitoring device is available where required;				
		d) list of procedures done.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT					
TOPIC 9J.5: SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES STANDARD 9J.5.1The Head of Surgical Services shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Surgical Services. The Head of Surgical Services shall ensure compliance to monitoring of specific performance indicators.					
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9J.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Surgical Services. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.				
	EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to (f)			
		2. Records on performance improvement activities			
		3. Minutes of performance improvement meetings			
		4. Performance improvement studies			
		5. Mortality and morbidity audits with remedial actions			
		6. Records on innovation if available.			
	Facility Comments:				
9J.5.1.2	The Head of Surgical Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement activities to appropriate individual / personnel within the respective services.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes of meetings				
		2. Letter of assignment of responsibilities				
		3. Job description				
	Facility Comments:					
9J.5.1.3	The Head of Surgical Services shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility. Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.					
	EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:				
		a) Training of staff				
		b) Policy on incident reporting				
		c) Methodology of incident reporting				
		d) Register/records of incidents				
		2. Completed incident reports				
		3. Root Cause Analysis				
		4. Corrective and preventive action plans				
		5. Remedial measure				
		6. Minutes of meetings				
		7. Acknowledgment by Head of Service and PIC/Hospital Director				
		8. Feedback given to staff regarding incident reporting.				
	Facility Comments:					
9J.5.1.4 CORE	The staff including medical practitioners provide an appropriate peer group structure for performing the safety and performance improvement activities to accomplish clinical care evaluation.					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	a) The medical practitioners undertake clinical reviews of all risk assessments, incident reports, audits and safety and performance improvement activities: i) as a single committee for all safety and performance improvement activities; ii) in multidisciplinary committees within the service; iii) in a variety of purpose-specific committees, such as mortality and morbidity, infection control, blood transfusion, etc. b) Whatever structure is utilised, provision is made for review and analysis of the clinical work of each individual clinical service, department, unit or function.					
	EVIDENCE OF COMPLIANCE				1. Performance improvement activities	
	2. Minutes of meetings					
	3. Relevant reports and documents, e.g. clinical audit reports, incident reports, mortality and morbidity review reports, etc.					
	Facility Comments:					
9J.5.1.5 CORE	There is tracking and trending of specific performance indicators not limited to but at least two (2) of the following: a) number of mortality/morbidity audits/meetings being conducted in the department with documentation of cases discussed b) percentage of unplanned re-admission within 72 hours of discharge c) unplanned return to operating theatre within the same hospital admission following surgery d) percentage of patients with waiting time of more than seven (7) working days for fixation of long bone closed fracture					
EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored.					
2. Records on tracking and trending analysis.						
3. Minutes of mortality/morbidity audits meetings						
4. Remedial measures taken where appropriate						
Facility Comments:						
9J.5.1.6	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff.					
		2. Evidence of feedback via communication on results of performance improvement activities through continuing medical education/meetings.					
		3. Minutes of service/unit/committee meetings					
	Facility Comments:						
9J.5.1.7	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.						
	EVIDENCE OF COMPLIANCE	1. Documentation on performance improvement activities and performance indicators.					
		2. Policy statement on anonymity on patients and providers involved in performance improvement activities.					
	Facility Comments:						

SERVICE SUMMARY	
SURVEYOR SUMMARY:	
OVERALL RATING:	
OVERALL RISK:	

SURVEY ITEM & SELF-ASSESSMENT			
SERVICE STANDARD 9K: CLINICAL SERVICES – PALLIATIVE CARE SERVICES			
	PREAMBLE <i>Palliative Care services play an integral role in delivering comprehensive care to patients with serious illnesses and should be offered to all patients facing life-limiting conditions with serious health-related suffering who are treated in the Facility.</i> <i>The Palliative Care Services shall be organised, directed and coordinated with other services in the Facility to provide a high standard of inpatient and outpatient care to the community and cover the following:</i> <i>a) appropriateness of clinical care;</i> <i>b) high quality, standardised, timely and safe patient oriented clinical care.</i> <i>c) compassionate and empathic communication with patients and families.</i> <i>d) coordination of care according to patient needs</i> <i>e) ethical decision making</i> <i>In addition to the above, the Palliative Care Services also conduct teaching and training, and research and audit activities where applicable.</i>		
<u>TOPIC 9K.1:</u> <u>STANDARD 9K.1.1</u>	<u>ORGANISATION AND MANAGEMENT</u> <i>The Palliative Care Services shall be organised, directed and coordinated with other services in the Facility to provide a high standard of inpatient and outpatient care to the community in a safe, efficient, effective, evidence based and caring manner and with due regard for the needs, dignity and privacy of patients and confidentiality of their personal information. The Palliative Care Services shall be easily accessible and continuity of care assured.</i>		
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT SURVEYOR RATING

9K.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Palliative Care Services are clearly documented and measurable that indicates safety, quality and patient centred care. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.				
	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.			
		2. Goals and objectives of the Palliative Care Services in line with the Facility statements are available, endorsed and dated.			
		3. Evidence of planned reviews of the above statements.			
	4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)				
	5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.				
	Facility Comments:				
9K.1.1.2 CORE	There is an organisation chart which: a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head of Palliative Care Services, consultants, medical practitioners and staff of the Palliative Care Services; b) is accessible to all staff and clients; c) is revised when there is a major change in any of the following: i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns.				

	EVIDENCE OF COMPLIANCE	1. Clearly delineated current organisation chart with line of functions and reporting relationships the Person In Charge (PIC), Head of Palliative Care Services, consultants, medical practitioners and staff of the Palliative Care Services. 2. Organisation chart of the service is endorsed, dated and accessible. 3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).			
	Facility Comments:				
9K.1.1.3	The Governing Body shall ensure that the Palliative Care Services are organised in such a way as to: a) facilitate the provision of palliative care services to patients in the Facility in a safe, efficient, effective, and caring manner and with due regard for the needs, dignity and privacy of patients and confidentiality of their personal information; b) assure continuity of care; c) address the professional needs of the medical practitioners; d) ensure that the medical practitioners are involved in the formulation of policies and procedures concerning patient care appropriate to the scope of services of the Facility.				
	EVIDENCE OF COMPLIANCE	1. Department/Service operational policies that address (a) to (d). 2. Medical Staff By-Laws 3. Evidence of involvement of medical practitioners in the formulation of policies and procedures concerning patient care. 4. Involvement of Head of the Service in the Medical and Dental Advisory Committee/Medical Advisory Committee and ward meetings.			

		5. Minutes of meetings				
		6. Proper and adequate equipment according to current standards.				
	Facility Comments:					
9K.1.1.4	There is a mechanism to ensure effective interaction between the Palliative Care Services and the Governing Body on all clinical aspects of healthcare and other relevant matters in the Facility. This mechanism is defined in the policies of the Governing Body and is accomplished through: a) the appointment of a medical practitioner as the Head of Palliative Care Services delineating his/her authority, responsibilities and accountabilities in a written document according to the relevant Acts to manage and control the Palliative Care Services; b) Medical and Dental Advisory Committee (MDAC) to advise the Governing Body on issues related to clinical governance, i.e. in planning, coordinating, implementation, control and to improve activities relating to Palliative Care Services.					
	EVIDENCE OF COMPLIANCE	1. Letter of appointment/assignment and delineation of duties and responsibilities of the Head of the Service. 2. Letter of appointment and Terms of Reference as member of the Medical and Dental Advisory Committee/Medical Advisory Committee. 3. Minutes of meetings of MDAC/Management				
Facility Comments:						
9K.1.1.5 CORE	The Head of Palliative Care Services has: a) representation of the Service in committees and subcommittees where relevant; b) representation of the Service in clinical staff liaison meetings;					

	c) involvement and provide regular input to the Senior Management Team.					
	EVIDENCE OF COMPLIANCE	1. Letter of representation of the Head of Service in committees and subcommittees where relevant, e.g. Blood Transfusion Committee, Medical Records Committee, Hospital Infection and Antibiotic Control Committee, etc.				
		2. Minutes of meetings of committees				
		3. Minutes of meeting of Senior Management Team.				
Facility Comments:						
9K.1.1.6	The assessment, planning, direction, evaluation and continuity of clinical care are the responsibility of medical practitioners managing individual patients, thus ensuring clinical independence.					
EVIDENCE OF COMPLIANCE	1. Medical Staff By-Laws; clause indicate clinical care responsibility of medical practitioners.					
	2. Documented evidence of clinical notes in the patient's medical record; e.g. documentation on assessment, planning, direction, evaluation and continuity of clinical care, valid name stamp of medical practitioner. Appropriateness of follow-up in terms of time interval & number of different managing practitioners. Evidence of ownership of patients, in keeping with patient-centered care.					
	3. Documented evidence in clinical notes that there is no fragmentation of care of a patient between disciplines but there is teamwork when required.					
	4. Documented evidence in clinical notes that the indications for procedures done are valid.					
	5. Evidence in clinical notes that the general management is as per current practise.					

	Facility Comments:			
9K.1.1.7	The Head of Palliative Care Services shall be involved for the following aspects of management of the services: a) the preparation of budget and ensuring that expenditure remains within the budget allocated; b) human resource management and development; c) development of policies and procedures and ensuring compliance to them; d) facility and equipment management; e) safety and performance improvement activities and risk management.			
	EVIDENCE OF COMPLIANCE 1. Evidence of (a) to (e) in the minutes of meetings of Palliative Care Services indicate the involvement of Head of Service. 2. Endorsement of policies and procedures 3. Request for allocation of budget and staffing 4. Implementation of performance improvement activities (refer to Quality Improvement activities)			
	Facility Comments:			
9K.1.1.8	Regular staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Palliative Care Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.			
	EVIDENCE OF COMPLIANCE 1. Minutes are accessible, disseminated and acknowledged by the staff. 2. Attendance list of members with adequate representatives of the service.			

		3. Frequency of meetings as scheduled.				
		4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).				
	Facility Comments:					
9K.1.1.9	Where there are medical practitioners in training, there is evidence that: a) their responsibilities for patient care are documented; b) their training needs are identified; c) appropriate supervision and training are given to the medical practitioners concerned.					
	EVIDENCE OF COMPLIANCE	1. Structured training programmes for medical practitioners are in place. 2. Training timetable, continuing medical education and attendances list 3. Assessment reports 4. Log books				
	Facility Comments:					
9K.1.1.10	Appropriate statistics and records shall be maintained in relation to the provision of Palliative Care Services and used for managing the services and patient care purposes.					
	EVIDENCE OF COMPLIANCE	1. Records are available but not limited to the following: a) workload/census for inpatients and outpatients; b) annual report; c) accident/incident reports;				

		d) staffing number and staff profile;				
		e) staff training records;				
		f) data on performance improvement activities, including performance indicators.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT				
<u>TOPIC 9K.2:</u>	<u>HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT</u>			
<u>STANDARD 9K.2.1</u>	<u>CREDENTIALING AND PRIVILEGING</u> <i>The Palliative Care Services shall be directed by a qualified and competent medical practitioner, and staffed by suitably qualified and competent clinical personnel to achieve the goals and objectives of the Palliative Care Services.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9K.2.1.1 CORE	There is documented evidence of appropriate training and competency for the granting of clinical privileging. The criteria for determining privileges are specified and documented. There is a structured process to ensure the stated criteria are uniformly applied to all applicants. These include: a) the criteria are designed to assure that patients will receive safe and quality care; b) the criteria for individual procedures are documented in detail; e.g. competency records/log books, application from the individual practitioner, recommendations from peer/referee and minutes of meeting; c) competency for each performance is dated, verified and signed by the supervisors; d) the period of time for which the privileges are to be granted is specified; e) current registration with the local professional registration bodies, e.g. Malaysian Medical Council, National Specialist Register (NSR); f) peer recommendations are taken into account when privileges are being considered; g) the recommendations of the relevant department and/or major professional services for privileges to be granted are taken into consideration. h) outcome of privileged procedures must be documented			

	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures are established to govern the credentialing and privileging processes which include items (a) to (g).				
		2. Compliance with policy and criteria for credentialing and privileging				
		3. Annual Practising Certificate (APC), National Specialist Register (NSR) certificates and privileging certificates.				
		4. Recommendations from peer/referee				
	EVIDENCE OF COMPLIANCE	5. Availability of the list of procedures requiring credentialing and privileging.				
		6. Availability of list of procedures to include core procedures specific to the disciplines performed by medical officers; competency records/log books.				
		7. Availability of list of procedures and its outcomes performed by each practitioner. Should be linked to annual appraisal.				
Facility Comments:						
9K.2.1.2 CORE	EVIDENCE OF COMPLIANCE	Documented evidence of privileges conferred by the Governing Body is available and accessible to relevant staff at point of care.				
		1. Formal letter of assignment or certificate of privileging with stipulated timeline are issued and reviewed accordingly.				
		2. Updated list of staff with privileges conferred is made accessible at point of care.				
Facility Comments:						

9K.2.1.3	Clinical staff performs within the privileges conferred.					
	EVIDENCE OF COMPLIANCE	1. Verification of procedures performed by individuals at point of care within the awarded privileging rights with evidence of: a) List of procedures privileged. b) Clinical notes. The indication for the procedure clearly written				
		Facility Comments:				
9K.2.1.4	There are written and dated specific job descriptions for all categories of staff that include: a) qualification, training, experience and certification required for the position; b) lines of authority; c) accountability, functions, and responsibilities; d) reviewed when required and when there is a major change in any of the following: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations. e) administrative and clinical functions.					
EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e). 2. Job description includes specialisation skills 3. Relevant privileges granted where applicable					

		4. The job description is acknowledged by the staff and signed by the Head of Service and dated.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
<u>STANDARD</u> <u>9K.2.2</u>	<u>STAFF TRAINING, EDUCATION, APPRAISAL AND RESEARCH</u> <i>The Facility and all staff shall demonstrate an ongoing commitment to continuing medical education.</i>					
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9K.2.2.1	There are continuing education activities for staff including medical practitioners to pursue professional interests and to prepare for current and future changes in practice.					
	EVIDENCE OF COMPLIANCE	1. Training calendar includes in-house/external courses/ workshop/conferences				
		2. Contents of training programme				
		3. Training records on continuing education activities are kept and maintained for each staff including training in life support.				
		4. Certificate of attendance/degree/post basic training				
Facility Comments:						
9K.2.2.2	The educational needs of staff and the Facility, as evidenced by the results of medical-care evaluation such as incident reports, performance improvement studies and complaints, are taken into consideration when the content and structure of educational activities are planned.					
	EVIDENCE OF COMPLIANCE	1. Evidence of inclusion of results of audit activities, e.g. mortality and morbidity reviews, incident reporting, etc in educational activities.				
		2. Evidence of improvement made from corrective or preventive measures from incident reports.				

	Facility Comments:			
9K.2.2.3	In a Facility where undergraduate medical, nursing and allied health training programmes are conducted, the Facility shall ensure there are sufficient skilled trained staff to provide clinical supervision of students. The facility should also provide a suitable number of patients to trainee ratio. The number of trainees in each category of staff should be limited based on the patient load and case mix.			
EVIDENCE OF COMPLIANCE	1. Sufficient skilled trained staff to provide clinical supervision as per terms of Memorandum of Understanding. 2. Compliance with locally directed standards of training where applicable.			
	Facility Comments:			
9K.2.2.4	There is evidence of training needs assessment and staff development plan which provide the knowledge and skills required for staff to maintain competency in their current positions and future advancement.			
EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and gaps identified. 2. A staff development plan based on training needs assessment is available. 3. Training schedule/calendar is in place. 4. Training module			
	Facility Comments:			
9K.2.2.5	Staff including medical practitioners receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.			

	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff including medical practitioners is completed upon probationary period and as an annual exercise.				
	Facility Comments:					
9K.2.2.6	Where appropriate the Facility shall endeavour to undertake clinical research using available resources.					
	EVIDENCE OF COMPLIANCE	1. Documented evidence of research activities e.g. protocol, policies, consent etc.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT				
STANDARD 9K.2.3	<u>STAFFING LEVEL AND STAFF COMPETENCY</u> <i>The Head and staff of the Palliative Care Services including medical practitioners are individuals qualified by education, training and experience commensurate with the requirements of the various positions and relevant laws.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9K.2.3.1	Deployment of all service providers for Palliative Care Services takes the following factors into consideration: a) the number of persons deployed is proportional to the number of patients being cared for as in the regulatory requirements and for the intensity of care provided; b) the categories of service providers based on qualifications and experience providing care reflect the complexity of clinical problems being managed; c) staffing needs shall take into consideration absences due to leave or illness; double shift duties by clinical staff shall be documented and monitored; d) adequate staffing levels of appropriate competency shall be maintained throughout the hours the services are in operation. Where services need to be provided on a 24-hour basis, staffing level reflects the intensity of activities during each shift; e) where it is not possible to have service providers on duty on site, e.g. after working hours, provision is made for relevant medical practitioner to be available on call.			
	EVIDENCE OF COMPLIANCE 1. Documentation and planning on deployment of staff that includes but not limited to (a) to (e) with evidence of: i) deployment based on staff to patient ratio, bed occupancy rate and complexity of cases; ii) special skills/training of staff; iii) contingency plan during acute shortage;			

		iv) duty roster.				
		v) Evidence that staff and doctors are not made to work more than the limits set by different authorities.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT				
STANDARD 9K.2.4	STAFF ORIENTATION A structured orientation programme introduces new staff to their services, operational policies and relevant aspects of the Facility to prepare them for their roles and responsibilities.			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9K.2.4.1	There is a structured orientation programme for all newly appointed staff to the Palliative Care Services including medical practitioners and for those new to specific areas that include the following: a) explanation of the goals, objectives, policies and procedures of the Facility and those of the Palliative Care Services; b) lines of authority and areas of responsibility; c) explanation of particular duties and functions; d) explanation of the methods of assigning clinical care and the standards of clinical practice; e) handover communication; f) processes for resolving practice dilemmas; g) information about safety procedures; h) training in basic/advanced life support techniques; i) methods of obtaining appropriate resource materials; j) staff appraisal procedures for the Palliative Care Services; k) education on Patient and Family Rights; l) education on MSQH Standards requirements.			
	EVIDENCE OF COMPLIANCE 1. Policy requiring all new staff to attend a structured orientation programme 2. There is Palliative Care Services orientation programme with relevant topics not limited to topics covered from (a) to (l). 3. Attendance list			

	Facility Comments:			

SURVEY ITEM & SELF-ASSESSMENT						
<u>TOPIC 9K.3:</u>	<u>POLICIES AND PROCEDURES</u>					
<u>STANDARD 9K.3.1</u>	<u>DEVELOPMENT, DERIVATION AND DOCUMENTATION</u> <i>There are written and dated policies and procedures for all activities of the Palliative Care Services. These policies and procedures reflect current standards of medical practice, relevant regulations, statutory requirements, and the purposes of the services. These policies and procedures, terms of reference, by-laws, rules or regulations, state how the clinical staff including medical practitioners regulate themselves and provide patient care.</i>					
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9K.3.1.1 CORE	There are written policies and procedures for the Palliative Care Services which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated.					
	There is a mechanism for and evidence of a periodic review at least once in every three years.					
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for the service. 2. Policies and procedures are consistent with regulatory requirements and current standard practices. 3. Evidence of periodic review of policies and procedures. 4. The policies and procedures are endorsed and dated.				
	Facility Comments:					
9K.3.1.2	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved.					

	Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.					
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.				
		2. Minutes of meeting with evidence of cross reference with other departments				
		3. Documented cross departmental policies				
Facility Comments:						
9K.3.1.3 CORE	The policies and procedures documentation shall address at least the following topics and any others as required by relevant standards and laws: a) description of the organisational structure of the Palliative Care Services; b) clinical practice guidelines; c) clinical documentation includes pain (or relevant presenting symptom / clinical alarm system) as the 5 th vital sign where appropriate; d) handover communication; e) drug prescription, dispensing and administration; f) blood transfusion; g) continuing of care including regular review of patient, review of investigation results, discharge (planned or At Own Risk), referrals and escort as necessary; h) pain management; i) management of patients under police custody/prisoner; j) management of cases with an infectious disease including notification of notifiable diseases; k) the responsibilities of the staff including medical practitioners in relation to internal and external disasters are documented, and known to the staff (contingency plan); l) incident reports shall be compiled, investigated, discussed and recorded and action plans implemented; m) end of life care; n) management of a death.					

	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures that address but not limited to (a) to (n).				
	Facility Comments:					
9K.3.1.4	Current policies and procedures are communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/ Minutes of meetings 2. Circulation list and acknowledgement				
	Facility Comments:					
9K.3.1.5 CORE	There is evidence of compliance with policies and procedures.					
	EVIDENCE OF COMPLIANCE	1.Compliance with policies and procedures through: a) interview of staff on practices; b) verify with observation on practices; c) results of audit on practices; d) practices in line with established policies and procedures. e) review of patient grievances relating to policies & procedures.				
	Facility Comments:					

9K.3.1.6	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.					
	EVIDENCE OF COMPLIANCE	1. Copies of relevant policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.				
	Facility Comments:					
9K.3.1.7	The services shall operate on a 24-hour basis providing a level of care appropriate to the activities of the patients in the Facility.					
	EVIDENCE OF COMPLIANCE	1. Operational policy on 24-hour services 2. Staffing level reflects good mix of experienced staff and the intensity of activities during each shift. 3. On-call roster is dated and authorised.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT					
<u>TOPIC 9K.4:</u> <u>FACILITIES AND EQUIPMENT</u> <u>STANDARD 9K.4.1</u> <i>The Head of Palliative Care Services shall ensure adequate facilities and equipment that are safe and appropriate are available for the staff to function effectively and to meet the goals and objectives of the Palliative Care Services.</i>					
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
9K.4.1.1	There are adequate and appropriate facilities and equipment with proper utilisation of space to enable staff to carry out their professional, teaching and administrative functions.				
	EVIDENCE OF COMPLIANCE	1. Adequate and proper utilisation of space. 2. Appropriate type of equipment to match the complexity of services. 3. Adequate facilities and equipment at each patient care area for safe care. (e.g. defibrillators, emergency cart, hand washing facilities etc) 4. Easy access and clear exit routes 5. Absence of overcrowding 6. Availability of areas to isolate patients who may aerosolize pathogens 7. Availability of private areas for family discussions and care of the dying patient.			
	Facility Comments:				

9K.4.1.2	Existing facilities shall take cognisance of the safety of staff and patients.					
	EVIDENCE OF COMPLIANCE	1. Design and layout of the unit, e.g. wards, treatment rooms, dirty and clean utility rooms, access, lighting, signage, etc address the safety aspects of patients and staff. 2. Adequate equipment and supplies for Palliative Care Services, e.g. infusion pumps, functioning patient call bell, ripple mattress etc. 3. Equipment should have scheduled planned preventive maintenance (PPM).				
	Facility Comments:					
9K.4.1.3	Suitable and adequate forms of communication and intercommunication systems and equipment are provided to enable clinical staff to communicate among themselves and with the other members of the healthcare team.					
	EVIDENCE OF COMPLIANCE	1. Appropriate telecommunication modalities available for daily operation and during emergencies.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
<u>STANDARD</u> <u>9K.4.2</u>	<u>FACILITIES AND EQUIPMENT FOR PATIENT CARE</u> <i>Adequate facilities and equipment shall be available to provide safe and effective patient care.</i>					
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
9K.4.2.1	Facilities are suitably located to facilitate easy access and to provide an atmosphere of user, environmental and 'disabled' friendly.					
	EVIDENCE OF COMPLIANCE	1. Floor plan indicates accessibility and patient and user friendly. 2. Feedback from patient satisfaction survey 3. Incident reporting relating to facilities if any.				
	Facility Comments:					
9K.4.2.2	Equipment, both for emergency and non-emergency usage, shall be appropriate to the level of care.					
	EVIDENCE OF COMPLIANCE	1. Availability of emergency and non-emergency equipment appropriate to level of care, such as defibrillator, emergency trolley, suction machine, electrocardiogram (ECG) machine, infusion or syringe pump, vital sign monitor, etc. 2. Scheduled checking of items in emergency trolley.				
	Facility Comments:					
9K.4.2.3	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.					

	EVIDENCE OF COMPLIANCE	1. Testing, commissioning and calibration records (certificates or stickers). 2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as evidence of compliance to the relevant standards and Acts.				
	Facility Comments:					
9K.4.2.4 CORE	There is evidence that the facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.					
	EVIDENCE OF COMPLIANCE	1. Planned Preventive Maintenance records such as schedule, stickers, etc. 2. Planned Replacement Programme where applicable 3. Complaint records 4. Asset inventory				
	Facility Comments:					
9K.4.2.5	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.					
	EVIDENCE OF COMPLIANCE	1. User training records 2. Competency assessment record 3. Letter of authorisation 4. List of staff trained and authorised to operate specialised equipment				
	Facility Comments:					

9K.4.2.6	Equipment is upgraded (based on evidence) from time to time so as to keep pace with advancement in operative and diagnostic techniques and technology.			
	EVIDENCE OF COMPLIANCE	1. Equipment are being replaced and upgraded to meet current standard of care and advancement in technology in a planned and systematic manner.		
	Facility Comments:			

SURVEY ITEM & SELF-ASSESSMENT				
STANDARD 9K.4.3	<u>FACILITIES FOR PALLIATIVE CARE OUTPATIENT SERVICES</u> <i>Where specialist outpatient palliative care services are provided, there are adequate outpatient clinics to enable the provision of safe and effective patient care; and patient privacy and confidentiality are assured.</i>			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT
				SURVEYOR RATING
9K.4.3.1	The Palliative Care Outpatient Services shall have the following features: a) the organisation and management of the clinics are planned so as to ensure prompt attention to patients, minimal waiting time, and avoidance of unnecessary visits by the patients; b) record keeping shall be efficient; c) an appointment or queuing system is used to manage patient consultations; d) the clinic is easily accessible including for non-ambulant patients and is easily identified through adequate signage; e) the clinic is located close to other facilities, e.g. radiology, laboratories and pharmacy; f) adequate provision is made for patient comfort g) Call back system for patients defaulting appointments (esp for high risk cases) h) Avenue for patients to access service between appointments.			
	EVIDENCE OF COMPLIANCE	i. The Palliative Care Outpatient Services address (a) to (f) with evidence of but not limited to the following: i) list of services available and offered to patients; ii) flow chart on work process;		

		iii) safe keeping of medical records; iv) security of data in Health Information System; v) clinic appointment system; vi) monitoring of waiting time; vii) adequate and appropriate signage; viii) floor plan indicates accessibility to supporting services and optimisation of space; ix) adequate patient personal use items, e.g. wheelchair, etc; x) adequate waiting area, rest rooms, refreshments, reading material and parking space.				
	Facility Comments:					
9K.4.3.2	Adequate numbers of rooms are provided to ensure patient privacy and confidentiality for various patient care activities including: a) consultation (not more than one patient in a room at any time); b) conduct of minor procedures and nursing procedures; maintain a register of procedures performed; c) performance of various tests.					
	EVIDENCE OF COMPLIANCE	1. Adequate facilities for consultation and patient care activities that address (a) to (c) with evidence of but not limited to the following: i) privacy of patient is ensured; ii) procedure room appropriately equipped;				

		iii) patient monitoring device is available where required;				
		iv) list of procedures done.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 9K.5:	SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES					
STANDARD 9K.5.1	The Head of Palliative Care Services shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Palliative Care Services. The Head of Palliative Care Services shall ensure compliance to monitoring of specific performance indicators.					
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
9K.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Palliative Care Services. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.					
	<table><tr><td>EVIDENCE OF COMPLIANCE</td><td> 1. Planned performance improvement activities include (a) to (f) 2. Records on performance improvement activities 3. Minutes of performance improvement meetings 4. Performance improvement studies 5. Mortality and morbidity audits with remedial actions 6. Records on innovation if available. </td><td></td></tr></table>	EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to (f) 2. Records on performance improvement activities 3. Minutes of performance improvement meetings 4. Performance improvement studies 5. Mortality and morbidity audits with remedial actions 6. Records on innovation if available.			
EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to (f) 2. Records on performance improvement activities 3. Minutes of performance improvement meetings 4. Performance improvement studies 5. Mortality and morbidity audits with remedial actions 6. Records on innovation if available.					
	Facility Comments:					

9K.5.1.2	The Head of Palliative Care Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement activities to appropriate individual/ personnel within the respective services.				
	EVIDENCE OF COMPLIANCE	1. Minutes of meetings 2. Letter of assignment of responsibilities 3. Job description			
	Facility Comments:				
9K.5.1.3	The Head of Palliative Care Services shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility.				
	Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.				
	EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include: a) Training of staff b) Policy on incident reporting c) Methodology of incident reporting d) Register/records of incidents 2. Completed incident reports 3. Root Cause Analysis 4. Corrective and preventive action plans 5. Remedial measure 6. Minutes of meetings 7. Acknowledgment by Head of Service and PIC/Hospital Director			

	8. Feedback given to staff regarding incident reporting.				
	Facility Comments:				
9K.5.1.4 CORE	The staff including medical practitioners provide an appropriate peer group structure for performing the safety and performance improvement activities to accomplish clinical care evaluation.				
	a) The medical practitioners undertake clinical reviews of all risk assessments, incident reports, audits and safety and performance improvement activities:				
	i) as a single committee for all safety and performance improvement activities; ii) in multidisciplinary committees within the service; iii) in a variety of purpose-specific committees, such as mortality and morbidity, infection control, blood transfusion, etc.				
	b) Whatever structure is utilised, provision is made for review and analysis of the clinical work of each individual clinical service, department, unit or function.				
	EVIDENCE OF COMPLIANCE	1. Performance improvement activities 2. Minutes of meetings 3. Relevant reports and documents, e.g. clinical audit reports, incident reports, mortality and morbidity review reports, etc.			
	Facility Comments:				
9K.5.1.5 CORE	There is tracking and trending of specific performance indicators not limited to but at least two (2) of the following:				
	a) percentage of unplanned re-admission for the same complain within 72 hours of discharge				
	b) Percentage of patients with severe pain on initial encounter whose pain had been significantly reduced within 24 hours of therapy				

	c) number of medication errors involving opioid usage and administration d) number of palliative care patients dying without proper documentation on end-of-life care discussions e) percentage of palliative care patients receiving at least 1 spiritual care assessment during admission. f) Percentage of patients experiencing procedure related complications (eg. Infected subcutaneous canula site, infected pigtail catheter, catheter related sepsis etc)			
	EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored. 2. Records on tracking and trending analysis. 3. Minutes of mortality/morbidity audits meetings 4. Remedial measures taken where appropriate		
	Facility Comments:			
9K.5.1.6	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.			
	EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff. 2. Evidence of feedback via communication on results of performance improvement activities through continuing medical education/meetings. 3. Minutes of service/unit/committee meetings		
	Facility Comments:			

9K.5.1.7	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.					
	EVIDENCE OF COMPLIANCE	1. Documentation on performance improvement activities and performance indicators.				
		2. Policy statement on anonymity on patients and providers involved in performance improvement activities.				
	Facility Comments:					

SERVICE SUMMARY	
Surveyor Summary:	
Overall Rating:	
Risk:	

SURVEY ITEM & SELF-ASSESSMENT				
SERVICE STANDARD 10 : ANAESTHETIC SERVICES				
	PREAMBLE <i>The Anaesthetic Services are provided by a team of highly trained and experienced specialists, known as anaesthetists. Anaesthetists are a key part of the team when surgery is being performed. They shall safely administer the right level of anaesthetic and monitor patients while they are anaesthetised to ensure they remain safe.</i> <i>In addition to providing care during perioperative period, intensive care, high dependency and resuscitation services, as well as teaching and training, research and audit, anaesthetists are also involved in providing special services that include the following but not limited to:</i> a) Pain Management Units: <i>i) Acute Pain Service (APS)</i> <i>ii) Chronic Pain Clinics</i> <i>iii) Obstetric analgesia service</i> b) Anaesthetic clinics for preoperative assessment of patients scheduled for surgery/ procedure requiring anaesthesia.			
TOPIC 10.1: STANDARD 10.1.1	ORGANISATION AND MANAGEMENT <i>The Anaesthetic Services shall be organised and administered to provide safe and efficient anaesthesia, intensive care, and pain management for patients. It works in collaboration with other related departments and services of the Facility.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
10.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Anaesthetic Services are clearly documented and measurable that indicates safety, quality and patient centred care. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.					
		2. Goals and objectives of the Anaesthetic Services in line with the Facility statements are available, endorsed and dated.					
		3. Evidence of planned reviews of the above statements.					
		4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)					
		5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.					
	Facility Comments:						
10.1.1.2 CORE	There is an organisation chart which: a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head of the Anaesthetic Services, consultants, medical practitioners and staff of the Anaesthetic Services; b) is accessible to all staff and clients; c) includes off-site services if applicable; d) is revised when there is a major change in any of the following: i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns.						
	EVIDENCE OF COMPLIANCE	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head of the Anaesthetic Services, consultants, medical practitioners and staff of the Anaesthetic Services.					
		2. Organisation chart of the service is endorsed, dated and accessible.					
		3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).					
	Facility Comments:						

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
10.1.1.3	Regular staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Anaesthetic Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.						
	EVIDENCE OF COMPLIANCE	1. Minutes are accessible, disseminated and acknowledged by the staff.					
		2. Attendance list of members with adequate representatives of the service.					
		3. Frequency of meetings as scheduled.					
		4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).					
	Facility Comments:						
10.1.1.4	The Head of the Anaesthetic Services is involved in the planning, justification and management of the budget and resource utilisation of the services.						
	EVIDENCE OF COMPLIANCE	1. Minutes of Facility-wide management meeting					
		2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service.					
		3. Approved budget and resources.					
	Facility Comments:						
	10.1.1.5	The Head of Anaesthetic Services is involved in the appointment and/OR assignment of staff.					
EVIDENCE OF COMPLIANCE		1. Records on staff interview (if applicable)					
		2. Appointment/assignment letter of Head of Service					
		3. Job description of Head of Service					
		4. Records on staff deployment					
		5. Duty roster					
Facility Comments:							

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
10.1.1.6	The Anaesthetic Services shall be represented on the Operating Theatre Committee which advises and sets guidelines for the Operating Suite Services.							
	EVIDENCE OF COMPLIANCE	1. Appointment letter of Head of Service in Operating Theatre (OT) Committee						
		2. Terms of Reference						
		3. Minutes of OT Committee meetings						
	Facility Comments:							
10.1.1.7	The Anaesthetic Services support and maintain responsibility for general intensive care services of the Facility.							
	EVIDENCE OF COMPLIANCE	1. List of services provided to other Units in the Facility by the Anaesthetic Services.						
		2. Documented responsibility for General Intensive Care Services.						
	Facility Comments:							
10.1.1.8	Where a Facility provides obstetric services, the Anaesthetic Services shall be responsible for the provision of safe and efficient anaesthetic services to obstetric patients.							
	EVIDENCE OF COMPLIANCE	1. List of services provided to other Units in the Facility by the Anaesthetic Services.						
		2. Documented responsibility for safe anaesthetic services to obstetric patients.						
	Facility Comments:							
10.1.1.9	Appropriate statistics and records shall be maintained in relation to the provision of Anaesthetic Services and used for managing the services and patient care purposes.							

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS				
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING			
	EVIDENCE OF COMPLIANCE	1. Records are available but not limited to the following:							
		a) workload on types of anaesthesia and nature of surgeries and trending;							
		b) intensive care workload such as number of admissions, bed occupancy rate, ventilator days and average length of stay;							
		c) annual report;							
		d) accident/incident reports;							
		e) staffing number and staff profile;							
		f) staff training records;							
		g) data on performance improvement activities, including performance indicators.							
	Facility Comments:								

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 10.2:	<u>HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT</u>					
STANDARD 10.2.1	<i>The Anaesthetic Services shall be directed by a qualified and competent anaesthetist/medical practitioner, and staffed by suitably qualified and competent clinical staff to achieve the goals and objectives of the Anaesthetic Services. Staff of the Anaesthetic Services have access to appropriate education programmes to maintain and improve their knowledge and skills.</i>					
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
10.2.1.1	The Head and staff of the Anaesthetic Services shall be individuals qualified by education, training, experience and certification to commensurate with the requirements of the various positions.					
	EVIDENCE OF COMPLIANCE	1. Records on credentials of Head of Service and staff required to fill up the posts within the service (to match the complexity of the Facility and services) and certification/registration.				
		2. Appointment/assignment letters				
		3. Certification				
		4. Training and competency records				
	Facility Comments:					
10.2.1.2	The authority, responsibilities and accountabilities of the Head of Anaesthetic Services are clearly delineated and documented. The Head of Service shall ensure the following: a) availability of equipment, drugs, and agents necessary for the safe administration of anaesthesia; b) application of appropriate techniques essential to the proper care of the anaesthetised patients; c) documentation and maintenance of records relating to the conduct of anaesthesia. These records shall be maintained in a form suitable for evaluating the quality of care; d) compilation of appropriate statistics relating to anaesthetic services activities; e) documentation of administrative policies and procedures; f) arrangements for staff to be on duty for provision of emergency anaesthetic services;					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	g) regular meetings of anaesthetic staff for clinical review and educational activities. Such meetings shall also address matters on policy and administration, as appropriate and minuted; h) participation and cooperation of representatives of other departments or services in formulating policies and procedures to provide uniform quality of anaesthetic services in the Facility.				
	EVIDENCE OF COMPLIANCE	1. Appointment/assignment letter for Head of Service.			
		2. Description of duties and responsibilities covers but not limited to those listed (a) to (h) as evidenced by:			
		a) availability of adequate facilities and equipment and necessary medications and other drugs in the drug trolley;			
		b) documentation in patients' medical records indicate safe practise of anaesthesia;			
		c) anaesthetic records shows completeness of documentation including name of practitioner, drug charting, vital signs readings and perioperative events;			
		d) annual statistics on workload, types of anaesthesia, trending and nature of surgeries;			
		e) administrative policies, protocols and work instructions for nursing staff are available;			
		f) duty rosters for emergency operating room staffing and anaesthetic assistant for extra emergency operating room teams;			
		g) clinical review and educational programmes and attendance list;			
		h) minutes of meetings with other representatives in relation to policies and performance improvement initiatives.			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
10.2.1.3	Sufficient numbers of personnel and support staff with appropriate qualifications are employed to enable the services to meet the need of the services. This will include dedicated anaesthetic assistants (with post basic training) at least one (1) per operating theatre and staffing in recovery rooms to be at least one (1) qualified nurse to three (3) patients.					
	EVIDENCE OF COMPLIANCE	1. Number of staff and qualification commensurate with staffing norms and workload.				
		2. Staffing pattern				
		3. Job description for anaesthetic assistants and recovery nurses.				
		4. Duty roster for anaesthetic assistants and recovery nurses				
		5. Census and statistics				
	Facility Comments:					
10.2.1.4	There are written and dated specific job descriptions for all categories of staff that include: a) qualifications, training, experience and certification required for the position; b) lines of authority; c) accountability, functions, and responsibilities; d) reviewed when required and when there is a major change in any of the following: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations. e) administrative and clinical functions.					
	EVIDENCE OF COMPLIANCE	1. All staff shall have a personal file with information on documentation on their qualifications, training and level of experience.				
		2. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e).				
		3. Job description includes specialisation skills				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	4. Relevant privileges granted where applicable.				
	5. The job description is acknowledged by the staff and signed by the Head of Service and dated.				
	Facility Comments:				
10.2.1.5	Personnel records on training, staff development, leave and others are maintained for every staff. Note: <i>Staff personal record may be kept in Human Resource Department as per Facility policy.</i>				
	EVIDENCE OF COMPLIANCE	1. Staff personal records include:			
		a) staff biodata;			
		b) qualification and experience;			
		c) evidence of current registration;			
		d) training record;			
		e) competency record and privileging;			
		f) leave record;			
		g) confidentiality agreement.			
	Facility Comments:				
10.2.1.6 CORE	The Anaesthetic Services shall ensure that anaesthesia is performed by qualified specialists and trained medical practitioners under the supervision of specialists and comply as follows: a) medical practitioner appointments in anaesthesia shall be made on the basis of demonstrated competence, availability and qualifications; b) a credentialing process shall be set in place to privilege other medical practitioners (i.e. medical officers) recognising their experience, in instances where the availability of staff with postgraduate qualifications in anaesthetics is difficult to obtain. Their experience/training shall be from performing anaesthesia on a full-time basis;				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	c) trainee medical practitioners in the Anaesthetic Services shall be directly supervised by an appropriately qualified or experienced anaesthetist to the standards set down by Training Boards; d) staffing is adequate to ensure that the same standard of anaesthetic competence is available for all emergencies and elective procedures. Each anaesthetist shall provide anaesthesia for only one patient at any one time; e) Anaesthetic services shall be available 24 hours per day, as required by the Facility's scope of services through an on call roster.			
	EVIDENCE OF COMPLIANCE			
	1. National Specialist Register (NSR) certificates for Anaesthetists			
	2. Assignment of medical practitioners in the Anaesthetic Services address (a) to (c)			
	3. Certificate of credentialing and privileging			
	4. Ratio of specialists to trainees (where applicable)			
	5. Work schedules and on-call rosters for specialists and medical officers			
	6. Policy on stay-in call for specialist or calling for direct specialist participation in emergency surgery			
	7. Documented evidence and verification of assignment of one anaesthetist to one patient at any one time of surgery.			
	Facility Comments:			
10.2.1.7	There is a structured orientation programme for all newly appointed staff to the Anaesthetic Services including medical practitioners and for those new to specific areas that include the following: a) explanation of the goals, objectives, policies and procedures of the Facility and those of the Anaesthetic Services; b) lines of authority and areas of responsibility;			

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS				
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING			
	c) explanation of particular duties and functions; d) explanation of the methods of assigning clinical care and the standards of clinical practice; e) handover communication; f) processes for resolving practice dilemmas; g) information about safety procedures; h) training in basic/advanced life support techniques; i) methods of obtaining appropriate resource materials; j) staff appraisal procedures for the Anaesthetic Services; k) education on Patient and Family Rights; l) education on MSQH Standards requirements.						
	EVIDENCE OF COMPLIANCE				1. Policy requiring all new staff to attend a structured orientation programme.		
					2. There is Anaesthetic Services orientation programme with relevant topics not limited to topics covered from (a) to (l)		
					3. Attendance list		
	Facility Comments:						
10.2.1.8	There is evidence of training needs assessment and staff development plan which provides the knowledge and skills required for staff to maintain competency in their current positions and future advancement.						
	EVIDENCE OF COMPLIANCE				1. Training needs assessment is carried out and gaps identified.		
					2. A staff development plan based on training needs assessment is available.		
					3. Training schedule/calendar is in place.		
					4. Training module		
					5. Privileging of Specialist and Medical Officer		
Facility Comments:							

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
10.2.1.9	There are continuing education activities for staff including medical practitioners to pursue professional interests and to prepare for current and future changes in practice.					
	EVIDENCE OF COMPLIANCE	1. Training calendar includes in-house/external courses/workshop/conferences				
		2. Contents of training programme				
		3. Training records on continuing education activities are kept and maintained for each staff.(e.g Teleconferencing, Webinar)				
		4. Certificate of attendance/degree/post basic training.				
	Facility Comments:					
10.2.1.10	Professional staff are actively assisted to attend relevant programmes conducted by their professional groups, other related associations, and educational institutions. Where the Facility cannot provide the necessary programme, cooperation is sought from external sources.					
	EVIDENCE OF COMPLIANCE	1. Records on continuing professional education activities for staff.				
		2. Training records for degree or post-graduate training programmes.				
		3. Certificate of attendance at conferences				
	Facility Comments:					
10.2.1.11	Staff including medical practitioners receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff including medical practitioners is completed upon probationary period and as an annual exercise.				
	Facility Comments:					
10.2.1.12	In facilities where trainee specialists, houseman and medical undergraduates are present, provision is made for their adequate training.					
	EVIDENCE OF COMPLIANCE	1. Sufficient skilled trained staff to provide clinical supervision as per terms of Memorandum of Understanding.				
		2. Log books				
		3. Assessment reports				
		4. Training timetable, continuing medical education and attendance list.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 10.3:		POLICIES AND PROCEDURES				
STANDARD 10.3.1		Documented policies and procedures shall reflect current knowledge and practice for the Anaesthetic Services and are consistent with the goals and objectives of the Anaesthetic Services and relevant regulations and statutory requirements.				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
10.3.1.1 CORE	There are written policies and procedures for the Anaesthetic Services which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated. There is a mechanism for and evidence of a periodic review at least once in every three years.					
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for the service.				
		2. Policies and procedures are consistent with regulatory requirements and current standard practices.				
		3. Evidence of periodic review of policies and procedures.				
		4. The policies and procedures are endorsed and dated.				
	Facility Comments:					
10.3.1.2	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved. Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.					
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.				
		2. Minutes of meeting with evidence of cross reference with other departments				
		3. Documented cross departmental policies				
	Facility Comments:					
10.3.1.3 CORE	Policies and procedures on Anaesthetic Services shall include the following:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	a) anaesthetic care shall comply with the College of Anaesthesia Guidelines or equivalent; b) the administration of anaesthesia to any patient is by a dedicated anaesthetist/privileged medical practitioner who is solely responsible for the care of the patient throughout the period of anaesthesia.					
	EVIDENCE OF COMPLIANCE	1. The following guidelines should be made available in the facility:				
		a) Recommendations for Patient Safety and Minimal Monitoring Standards during Anaesthesia and Recovery (2013)				
		b) Guidelines on Pre-operative Fasting (2008) or equivalent				
		c) Recommendations on Pre-anaesthetic assessment (2014)				
		d) Guidelines on Infection Control in Anaesthesia (2014)				
		e) Total Intravenous Anaesthesia (Pocket Reference,2013)				
		f) Recommendations for Minimal Standards for Inter-Facility Transport of Critically Ill Patients (2016)				
		g) Guidelines for the management of obese patient coming for surgery (2015)				
		h) The presence of dedicated anaesthetist/privileged medical practitioner who is solely responsible for the care of the patient per operation.				
		i) Rostering of manpower distribution in the operating room				
	Facility Comments:					
10.3.1.4	There are written guidelines or protocol for patients undergoing all anaesthetic and sedation procedures.					
	EVIDENCE OF COMPLIANCE	1. Documented guidelines/protocols for patients undergoing anaesthetic and sedation procedures				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	Facility Comments:				
10.3.1.5 CORE	Separate documented informed consent for anaesthesia or sedation shall be obtained by the anaesthetist from the patient OR family members where applicable according to existing laws.				
	EVIDENCE OF COMPLIANCE	1. Policy for consent taking			
		2. Anaesthetic consent form developed in accordance with the Malaysian Medical Council guidelines.			
	Facility Comments:				
10.3.1.6	All patients for surgery shall be assessed preoperatively by the anaesthetist and details of the assessment documented in the patient medical records or anaesthetic form.				
	EVIDENCE OF COMPLIANCE	1. Verification of evidence of pre-operative assessment by anaesthetist in patient's medical records or Anaesthetic forms.			
	Facility Comments:				
10.3.1.7	All anaesthetic procedures shall comply with standard infection control guidelines to prevent cross infection between patients. Breathing apparatus shall not be shared and disposable items shall not be reused.				
	EVIDENCE OF COMPLIANCE	1. Guidelines on infection control policy in the operating theatre are available and adhered to.			
		2. Reusable anaesthetic items and equipment are sterilised according to infection control guidelines.			
		3. Single use anaesthetic items are disposed after each use.			
	Facility Comments:				
10.3.1.8	Current policies and procedures are communicated and made accessible to all staff.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings				
		2. Circulation list and acknowledgement				
	Facility Comments:					
10.3.1.9	Safe conduct of anaesthesia shall include but not limited to the following practices: a) pre-anaesthetic assessment; b) adherence to fasting protocol; c) various levels of checks on the anaesthetic machines; d) labelling of loaded syringes; e) pre-induction assessment of patient's vital signs and safety check list as per World Health Organization (WHO) recommendation; f) post-anaesthesia monitoring and documented criteria for discharge. The patient shall be reviewed by the anaesthetist before discharge from the recovery room (including objective scoring before discharge); g) post-operative acute pain management by the anaesthetist shall be encouraged. In the absence of the anaesthetist, the operating surgeon shall address the pain relief.					
EVIDENCE OF COMPLIANCE	1. The practice of safe anaesthesia address requirements as listed (a) to (g)					
	2. Verification of the following:					
	a) pre-anaesthetic assessment documented in the patient's medical records or anaesthetic records with pre-operative orders and instructions carried out;					
	b) fasting instructions are documented and compliance to fasting orders carried out in nursing notes;					
	c) daily check of anaesthetic equipment;					
	d) evidence of compliance to WHO checklist (Save Surgery Saves Lives);					
e) post-anaesthesia monitoring recorded in the anaesthetic records or patient medical records;						

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		f) discharge from post-anaesthetic unit by the anaesthetic specialist or doctor assigned with the responsibility;				
		g) scoring system used to document fitness for discharge and proper handover of patient to the receiving team from the ward;				
		h) policy on post-operative pain management and documentation of pain scores;				
		i) technique of pain management based upon patient factors and resources available;				
		3. References for pain management are available e.g. Pain Management Handbook (Ministry of Health, current edition)				
	Facility Comments:					
10.3.1.10 CORE	There is evidence of compliance with policies and procedures.					
	EVIDENCE OF COMPLIANCE	1. Compliance with policies and procedures through:				
		a) interview of staff on practices;				
		b) verify with observation on practices;				
		c) results of audit on practices;				
		d) practices in line with established policies and procedures.				
	Facility Comments:					
10.3.1.11	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff (including Malaysian Medical Council guidelines on consent).					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 10.4:		<u>FACILITIES AND EQUIPMENT</u>				
STANDARD 10.4.1		<i>The facilities and equipment in any designated area where anaesthesia is administered are adequate and appropriate for the safe delivery of anaesthesia and resuscitation.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
10.4.1.1	There are adequate and appropriate facilities and equipment with proper utilisation of space to enable staff to carry out their professional, teaching and administrative functions.					
	EVIDENCE OF COMPLIANCE	1. Adequate and proper utilisation of space.				
		2. Appropriate type of equipment to match the complexity of services.				
		3. Adequate facilities and equipment at each patient care area for safe care. (e.g. anaesthetic machines, Anaesthetic Gas Scavenging System, defibrillators, emergency cart, hand washing facilities, etc)				
		4. Easy access and clear exit routes				
	Facility Comments:					
10.4.1.2	Facilities used for induction of anaesthesia shall be designed and equipped for safe practice. If regional blocks are performed outside of the Operating Room, then it shall be done in areas with proper monitoring and resuscitation facilities.					
	EVIDENCE OF COMPLIANCE	1. Performance of regional blocks is done in areas with proper monitoring and resuscitation facilities.				
	Facility Comments:					
10.4.1.3	Areas where anaesthesia is administered comply with Medical Gas System requirements and standards set by relevant authorities.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	EVIDENCE OF COMPLIANCE	1. Presence of gas panel with auditory and visual alarms in the operating room.						
		2. The alarm system is checked regularly by trained personnel and documented.						
	Facility Comments:							
10.4.1.4 CORE	Facilities including emergency equipment and drugs shall be readily available in operating rooms and recovery areas for resuscitation purposes.							
	EVIDENCE OF COMPLIANCE	1. Emergency resuscitation trolley with defibrillator is easily available.						
		2. Presence of difficult intubation trolley, complete with airway devices and algorithm for CICV (can't intubate, can't ventilate) scenario.						
		3. Protocol for management of malignant hyperthermia (MH) and local anaesthetic toxicity, including statement on accessibility of drugs to treat these specific conditions are available.						
	Facility Comments:							
10.4.1.5	There shall be adequate space for patient recovery from anaesthesia with minimum 1.5 recovery bay to 1 operating room, i.e. 2 recovery bays for 1 operating room, 3 recovery bays for 2 operating rooms, 5 recovery bays for 3 operating rooms etc. The recovery room shall be appropriately staffed and equipped for resuscitation and monitoring. The nurse to patient ratio shall be based on patient's conscious level i.e.1:1 for unconscious patient and 1:3 for conscious patients.							
	EVIDENCE OF COMPLIANCE	1. The patient recovery area is in the vicinity of the operating room and readily accessible to the anaesthetist.						
		2. Availability of resuscitation equipment in case of emergency.						
		3. Adequate number of nurses according to norms and suitably qualified and trained to assist in anaesthetic emergencies.						
	Facility Comments:							

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
10.4.1.6	Anaesthetic delivery systems shall be kept in good condition with regular maintenance and there is a system to respond immediately to breakdown repair.					
	EVIDENCE OF COMPLIANCE	1. Documented evidence of maintenance records on all equipment used in the delivery of anaesthesia				
		2. System on respond to breakdown repair				
	Facility Comments:					
10.4.1.7 CORE	All patients who are anaesthetised shall have adequate monitoring as specified by the document “Safety Standards for Anaesthesia and Recovery” published by the Malaysian Society of Anaesthesiologists. The monitoring shall include the minimum of monitoring of electrocardiogram (ECG), blood pressure, pulse, respiration, oxygen saturation, capnometry and others as may be necessary.					
	EVIDENCE OF COMPLIANCE	1. Compliance to standard guidelines on monitoring of anaesthetised patients, i.e. “Safety Standards for Anaesthesia and Recovery”.				
		Facility Comments:				
10.4.1.8	Anaesthetic delivery systems shall have safety features to prevent accidental hypoxia or disconnection of breathing circuits during mechanical ventilation. These will include anti-hypoxic devices, gas module, alarms for oxygen pressure failure, and ventilator disconnect alarms.					
	EVIDENCE OF COMPLIANCE	1. Availability of general anaesthesia (GA) machines with the required safety features.				
		Facility Comments:				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
10.4.1.9	Anaesthetic waste gases and vapours shall be scavenged.				
	EVIDENCE OF COMPLIANCE	1. Evidence of functional Anaesthetic Gas Scavenging Systems			
	Facility Comments:				
10.4.1.10	Anaesthetic services for locations outside the operating suite shall also comply with the same anaesthetic standards set out for the operating suite. These locations may include facilities for endoscopy, radio-imaging, electroconvulsive therapy and radiotherapy.				
	EVIDENCE OF COMPLIANCE	1. Compliance to safe work processes and standards for anaesthetic services for locations outside the operating suite.			
		2. Records on monitoring of staffing level and competency			
		3. Records on monitoring of equipment			
		4. Compliance to Safe Surgery Saves Lives checklist			
	Facility Comments:				
10.4.1.11	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.				
	EVIDENCE OF COMPLIANCE	1. Testing, commissioning and calibration records (certificates or stickers)			
		2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as evidence of compliance to the relevant standards and Acts.			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
10.4.1.12	Electrical installation and supply, and electrically operated medical equipment comply with standards set by relevant authorities i.e. National Energy Commission and Electrical Engineers Code of Practice.					
	EVIDENCE OF COMPLIANCE	1. Electrical installation and supply and electrically operated equipment comply with relevant standards.				
	Facility Comments:					
10.4.1.13	Emergency power and suction complying with established standards shall be available in the event of supply failure. Uninterrupted power supply (UPS) shall be available for critical and life support equipment.					
	EVIDENCE OF COMPLIANCE	1. Emergency power and suction outlets comply with established standards				
		2. Availability of UPS power supply				
	Facility Comments:					
10.4.1.14	An emergency alert shall be available within the operating suite area to call for assistance in the event of a serious adverse event in any operating room.					
	EVIDENCE OF COMPLIANCE	1. Availability of emergency alert				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
10.4.1.15 CORE	There is evidence that the facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.					
	EVIDENCE OF COMPLIANCE	1. Planned Preventive Maintenance records such as schedule, stickers, etc.				
		2. Planned Replacement Programme where applicable				
		3. Complaint records				
		4. Asset inventory				
	Facility Comments:					
10.4.1.16	There shall be sufficient warming devices in the operating rooms and recovery areas to maintain optimum temperatures in patients undergoing surgery.					
	EVIDENCE OF COMPLIANCE	1. Sufficient warming devices available.				
	Facility Comments:					
10.4.1.17	There shall be facilities for rapid transfusion of fluids/blood in patients who have massive haemorrhage.					
	EVIDENCE OF COMPLIANCE	1. Availability of facilities for rapid transfusion of blood/fluids				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
10.4.1.18	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.					
	EVIDENCE OF COMPLIANCE	1. User training records				
		2. Competency assessment record				
		3. Letter of authorisation				
		4. List of staff trained and competent to operate specialised equipment				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 10.5:		<u>SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES</u>				
STANDARD <u>10.5.1</u>		<i>The Head of the Anaesthetic Services shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Anaesthetic Services. The Head of Anaesthetic Services shall ensure compliance to monitoring of specific performance indicators.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
10.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Anaesthetic Services. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.					
	EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to (f)				
		2. Records on performance improvement activities.				
		3. Minutes of performance improvement meetings				
		4. Performance improvement studies				
		5. Mortality and morbidity audits with remedial actions				
		6. Records on innovation if available				
	Facility Comments:					
10.5.1.2	The Head of Anaesthetic Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement to appropriate individual/personnel within the respective services.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes of meetings				
		2. Letter of assignment of responsibilities				
		3. Job description				
	Facility Comments:					
10.5.1.3	The Head of the Anaesthetic Services shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility. Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.					
	EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:				
		a) Training of staff				
		b) Policy on incident reporting				
		c) Methodology of incident reporting				
		d) Register/records of incidents				
		2. Completed incident reports				
		3. Root Cause Analysis				
		4. Corrective and preventive action plans				
		5. Remedial measure				
		6. Minutes of meetings				
		7. Acknowledgment by Head of Service and PIC/Hospital Director				
		8. Feedback given to staff regarding incident reporting.				
	Facility Comments:					
10.5.1.4 CORE	There is tracking and trending of specific performance indicators not limited to but at least two (2) of the following and this shall include monitoring of pain score upon discharge and one other performance indicator: a) <u>Mandatory indicator:</u>					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	pain score on discharge from recovery room should be less than four (4) (Target: 100%) b) number of adverse events following regional anaesthesia, e.g. prolonged motor blockade, inadvertent dural puncture, Local Anaesthetic (LA) toxicity c) number of adverse events following positioning (sentinel event) d) number of patients having prolonged stay in recovery room for more than two (2) hours (sentinel event) e) patient satisfaction survey with acute pain service and anaesthetic clinic f) percentage of cancellation of elective cases after being passed in the anaesthetic clinic (Target: less than 10%) <u>Subspecialties units in the Anaesthetic Services</u> Subspecialties units in the Anaesthetic Services, e.g. Obstetrics and Gynaecology Services, cardiac anaesthesia, etc shall monitor any other two (2) indicators to support its goals and objectives.			
	EVIDENCE OF COMPLIANCE			
	1. Specific performance indicators monitored.			
	2. Records on tracking and trending analysis.			
	3. Remedial measures taken where appropriate			
	4. Mechanism for monitoring prolonged motor blockade due to regional anaesthesia should be in place (Bromage Scoring).			
10.5.1.5	Facility Comments:			
	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.			
	EVIDENCE OF COMPLIANCE			
	1. Results on safety and performance improvement activities are accessible to staff.			
	2. Evidence of feedback via communication on results of performance improvement activities through continuing medical education/meetings.			
	3. Minutes of service/unit/committee meetings			
	Facility Comments:			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
10.5.1.6	There is a mortality and morbidity review committee, and deaths occurring in relation to anaesthesia shall be referred to this committee. Perioperative mortality, morbidity, and incidents shall be discussed at departmental level to give staff opportunities for improvement.					
	EVIDENCE OF COMPLIANCE	1. Evidence of mortality and morbidity review and relevant critical incidents presentation with remedial actions formulated and implemented.				
	Facility Comments:					
10.5.1.7	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.					
	EVIDENCE OF COMPLIANCE	1. Documentation on performance improvement activities and performance indicators.				
		2. Policy statement on anonymity on patients and providers involved in performance improvement activities.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT													
<u>TOPIC 10.6:</u>	<u>SPECIAL REQUIREMENTS</u>												
<u>STANDARD 10.6.1</u>	<i>Where appropriate and possible, the Anaesthetic Services shall organise and operate special anaesthetic services to enhance safety and quality of patient care. These services shall be integrated with other related services of the Facility.</i>												
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS										
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING									
10.6.1.1	The Anaesthetic Services operate special services where some of the required characteristics of these services include the following but not limited to: a) Pain Management Units: i) Acute Pain Service (APS) ii) Chronic Pain Clinics iii) Obstetric analgesia service b) Anaesthetic Clinics for preoperative assessment of patients scheduled for surgery/ procedure requiring anaesthesia. c) Other anaesthesia related services which may be incorporated when facilities and personnel are available, e.g. Day Surgery.												
	<table><tr><td rowspan="4">EVIDENCE OF COMPLIANCE</td><td>1. Where these services are available there must be written policies and protocols, adequate manpower and equipment. (Refer Pain Management Handbook 2nd edition 2013)</td><td></td></tr><tr><td>2. Records and statistics on services delivered.</td><td></td></tr><tr><td>3. Written policies and protocols, adequate manpower and evidence of records and statistics of services delivered.</td><td></td></tr><tr><td>4. Where a multidisciplinary approach for pre-operative patient assessment is indicated, there is a policy and facility for this service.</td><td></td></tr></table>	EVIDENCE OF COMPLIANCE	1. Where these services are available there must be written policies and protocols, adequate manpower and equipment. (Refer Pain Management Handbook 2 nd edition 2013)		2. Records and statistics on services delivered.		3. Written policies and protocols, adequate manpower and evidence of records and statistics of services delivered.		4. Where a multidisciplinary approach for pre-operative patient assessment is indicated, there is a policy and facility for this service.				
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	4. Where a multidisciplinary approach for pre-operative patient assessment is indicated, there is a policy and facility for this service.												
	Facility Comments:												

SURVEYOR SUMMARY:

OVERALL RISK:

SURVEY ITEM & SELF-ASSESSMENT				
SERVICE STANDARD 11 : OPERATING SUITE SERVICES				
	<u>PREAMBLE</u> <i>The Operating Suite Services have combined multidisciplinary healthcare personnel, e.g. surgeons, anaesthetists, nurses, theatre technician and other support staff in delivering a high standard of comprehensive patient care to those who require operative procedures during their stay in Healthcare Facility.</i> <i>The multidisciplinary teams working in the operating suite provide operative care, anaesthetic, theatre care and recovery. Each aspect works together to provide a coherent working relationship, which ensures high levels of patient comfort, dignity and safety.</i> <i>The operating suite promotes a culture of safe and evidence based practice that is monitored to meet:</i> a) <i>expectations of patients;</i> b) <i>compliance with regulatory and statutory requirements;</i> c) <i>WHO Patient Safety Solutions</i> - <i>Safe Surgery Saves Lives</i>			
<u>TOPIC 11.1:</u> <u>STANDARD 11.1.1</u>	<u>ORGANISATION AND MANAGEMENT</u> <i>The Operating Suite Services shall be directed and organised to provide safe and efficient perioperative care for patients. The services shall be coordinated with other services of the Facility.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
11.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Operating Suite Services are clearly documented and measurable that indicates safety, quality and patient centred care. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.					
		2. Goals and objectives of the Operating Suite Services in line with the Facility statements are available, endorsed and dated.					
		3. Evidence of planned reviews of the above statements.					
		4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)					
		5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.					
	Facility Comments:						
11.1.1.2 CORE	There is an organisation chart which: a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head of the Operating Suite Services, consultants, medical practitioners and staff of the Operating Suite Services; b) is accessible to all staff and clients; c) includes off-site services if applicable; d) is revised when there is a major change in any of the following: i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns.						
	EVIDENCE OF COMPLIANCE	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head of the Operating Suite Services, consultants, medical practitioners and staff of the Operating Suite Services.					
		2. Organisation chart of the service is endorsed, dated and accessible.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		3. The organisation chart shall incorporate off-site Operating Suite Services offered by the facility.				
		4. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).				
	Facility Comments:					
11.1.1.3	Regular staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Operating Suite Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.					
	EVIDENCE OF COMPLIANCE	1. Minutes are accessible, disseminated and acknowledged by the staff.				
		2. Attendance list of members with adequate representatives of the service.				
		3. Frequency of meetings as scheduled.				
		4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).				
	Facility Comments:					
11.1.1.4	The Operating Suite Services shall be guided by an Operating Theatre (OT) Committee (a subcommittee of MDAC) which consists of multidisciplinary users and providers of services.					
	EVIDENCE OF COMPLIANCE	1. Letters of appointment for the Chairman and members of the Operating Theatre Committee.				
		2. Terms of Reference				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
11.1.1.5	The Operating Suite Services staff are represented on interdepartmental committees and involved in decision making on issues related to the provision of operating suite services.					
	EVIDENCE OF COMPLIANCE	1. List of Interdepartmental Committees where OT staff representation is evidenced				
		2. Minutes of Interdepartmental Committee meetings on issues related to the provision of operating suite services.				
	Facility Comments:					
11.1.1.6	The Head of Operating Suite Services is involved in the planning, justification and management of the budget and resource utilisation of the services.					
	EVIDENCE OF COMPLIANCE	1. Minutes of management meeting				
		2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service.				
		3. Approved budget and resources.				
	Facility Comments:					
11.1.1.7	The Head of Operating Suite Services is involved in the appointment and/OR assignment of staff.					
	EVIDENCE OF COMPLIANCE	1. Records on staff interview (if applicable)				
		2. Appointment/assignment letter of Head of Service				
		3. Job description of Head of Service				
		4. Records on staff deployment				
		5. Duty roster				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
11.1.1.8 CORE	The surgical and anaesthetic practices in the Operating Suite Services are consistent with the privileges conferred by the Credentialing and Privileging Committee and a copy of such privileges conferred shall be readily available upon request.					
	EVIDENCE OF COMPLIANCE	1. List of privileges conferred to each practitioner for procedures at the operating theatre is available on-site.				
		2. Records on registration with National Specialist Register (NSR) for all specialists				
	Facility Comments:					
11.1.1.9 CORE	The records maintained by the Operating Suite Services are adequate for clinical, medicolegal, and evaluation purposes and include the following:					
	a) consent taken by surgeon and anaesthetist in writing and documented according to guidelines;					
	b) a documented system for tissues/specimens sent for laboratory examination;					
	c) a register of operations performed within the suite;					
	d) standard anaesthetic and drug administration records and regulations relating to the control of drugs;					
	e) a record of the surgical procedure performed which shall also be written into the patient's medical record. Each record contains details of the procedure and personnel involved, the dressings applied and drainage systems inserted, prostheses used, and the postoperative orders. Such entries in the records are signed with designation of the surgeon and dated accordingly.					
	EVIDENCE OF COMPLIANCE	1. Records maintained at the operating suite includes but not limited to items listed (a) to (e).				
		2. Verification with on-site inspection of:				
a) consent taking as per Malaysian Medical Council Guidelines;						
b) specimen book;						
c) register on all operations done in the operating theatre;						
	d) drug administration records;					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		e) documentation on disposal of dangerous drugs as per Dangerous Drug Act (DDA) disposal guidelines;				
		f) patient medical records on details of procedure and surgeon/personnel involved.				
	Facility Comments:					
11.1.1.10	Documented evidence of the counting of accountable (e.g. gauze, instruments etc) items used and a copy of the record is included in the patient's medical record.					
	EVIDENCE OF COMPLIANCE	1. Swab count record in patient medical records				
	Facility Comments:					
11.1.1.11	Support services such as radiology, pathology, and blood bank are available. Effective communication and relationships with these services are maintained.					
	EVIDENCE OF COMPLIANCE	1. Cross departmental policies with related support services, i.e. blood bank.				
		2. Evidence of compliance to such policies as observed on-site.				
	Facility Comments:					
11.1.1.12	Appropriate statistics and records shall be maintained in relation to the provision of Operating Suite Services and used for managing the services and patient care purposes.					
	EVIDENCE OF COMPLIANCE	1. Records are available but not limited to the following:				
		a) workload/census;				
		b) annual report;				
		c) accident/incident reports;				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		d) staffing number and staff profile;				
		e) staff training records;				
		f) data on performance improvement activities, including performance indicators.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT				
TOPIC 11.2:	<u>HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT</u>			
STANDARD 11.2.1	<i>The Operating Suite Services shall be directed by a qualified and competent medical practitioner, and staffed by suitably qualified and competent clinical staff to achieve the goals and objectives of the services. Staff of the services have access to appropriate education programmes to maintain and improve their knowledge and skills.</i>			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT
				SURVEYOR RATING
11.2.1.1	The Head and staff of the Operating Suite Services shall be individuals qualified by education, training, experience and certification to commensurate with the requirements of the various positions.			
	EVIDENCE OF COMPLIANCE	1. Records on credentials of Head of Service and staff required to fill up the posts within the service (to match the complexity of the Facility and services) and certification/registration.		
		2. Appointment/assignment letters		
		3. Training and competency records		
	Facility Comments:			
11.2.1.2	The authority, responsibilities and accountabilities of the Head of Operating Suite Services are clearly delineated and documented.			
	EVIDENCE OF COMPLIANCE	1. Appointment/assignment letter for Head of Service.		
		2. Description of duties and responsibilities		
	Facility Comments:			
11.2.1.3	The Operating Suite Services are managed by a perioperative trained registered nurse who is experienced in operating suite nursing and who has management skills.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Letter of appointment and credentials of Operating Suite Services Nurse Manager/Sister				
	Facility Comments:					
11.2.1.4	Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the need of the services.					
	EVIDENCE OF COMPLIANCE	1. Number of staff and qualification should commensurate with workload.				
		2. Staffing pattern (60% of scrub nurses are perioperative trained or at least one perioperative trained nurse per operating room) and this will include dedicated anaesthetic assistants (with post basic training) at least one (1) per operating theatre and staffing in recovery rooms to be at least one (1) qualified nurse to three (3) patients.				
		3. Duty roster				
		4. Census and statistics				
	Facility Comments:					
11.2.1.5	There are written and dated specific job descriptions for all categories of staff that include:					
	a) qualifications, training, experience and certification required for the position; b) lines of authority; c) accountability, functions, and responsibilities; d) reviewed when required and when there is a major change in any of the following:					
	i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted;					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	v) staffing patterns; vi) Statutory Regulations. e) administrative and clinical functions.				
	EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e) for the proper functioning of the Operation Suite Services			
		2. Job description includes specialisation skills			
		3. Relevant privileges granted where applicable			
		4. The nature and scope of work of each staff is specified.			
		5. The job description is acknowledged by the staff and signed by the Head of Service and dated.			
	Facility Comments:				
11.2.1.6	Personnel records on training, staff development, leave and others are maintained for every staff. Note: <i>Staff personal record may be kept in Human Resource Department as per Facility policy.</i>				
EVIDENCE OF COMPLIANCE	1. Staff personal records include:				
	a) staff biodata;				
	b) qualification and experience;				
	c) evidence of current registration;				
	d) training record;				
	e) competency record and privileging;				
	f) leave record;				
g) confidentiality agreement.					
Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
11.2.1.7	There is a structured orientation programme for all newly appointed staff to the Operating Suite Services including medical practitioners and for those new to specific areas that include the following: a) explanation of the goals, objectives, policies and procedures of the Facility and those of the Operating Suite Services; b) lines of authority and areas of responsibility; c) explanation of particular duties and functions; d) explanation of the methods of assigning clinical care and the standards of clinical practice; e) handover communication; f) processes for resolving practice dilemmas; g) information about safety procedures; h) training in basic/advanced life support techniques; i) methods of obtaining appropriate resource materials; j) staff appraisal procedures for the Operating Suite Services; k) education on Patient and Family Rights; l) education on MSQH Standards requirements.					
	EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme.				
		2. There is Operating Suite Services orientation programme with relevant topics not limited to topics covered from (a) to (l).				
		3. Attendance list				
	Facility Comments:					
11.2.1.8	There is evidence of training needs assessment and staff development plan which provides the knowledge and skills required for staff to maintain competency in their current positions and future advancement.					
	EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and gaps identified.				
		2. A staff development plan based on training needs assessment is available.				
		3. Training schedule/calendar is in place.				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	4. Training module				
	Facility Comments:				
11.2.1.9	There are continuing education activities for staff including medical practitioners to pursue professional interests and to prepare for current and future changes in practice. Such programmes shall include but not limited to the following: a) new surgical, anaesthetic, and operating suite procedures; b) regular fire and evacuation drills; c) resuscitation techniques; d) the use of new equipment in surgical operations and its maintenance and calibration; e) prevention and control of infection.				
	EVIDENCE OF COMPLIANCE	1. Training calendar includes in-house/external courses/ workshop/conferences			
		2. Contents of training programme			
		3. Training records on continuing education activities are kept and maintained for each staff including training in life support.			
		4. Certificate of attendance/degree/post basic training.			
	Facility Comments:				
11.2.1.10	Professional staff are actively assisted to attend relevant programmes conducted by their professional groups, other related associations, and educational institutions. Where the Facility cannot provide the necessary programme, cooperation is sought from external sources.				
	EVIDENCE OF COMPLIANCE	1. Records on continuing professional education activities for staff.			
		2. Training records for degree or post-graduate training programmes			
		3. Certificate of attendance or CPD points at conferences			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
11.2.1.11	Staff including medical practitioners receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.					
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff including medical practitioners is completed upon probationary period and as an annual exercise.				
	Facility Comments:					
11.2.1.12	In a teaching facility, the Operating Suite Services shall provide educational needs and teaching for undergraduates and postgraduates without compromising patient safety and comfort.					
	EVIDENCE OF COMPLIANCE	1. Memorandum of Understanding (MOU)				
		2. Compliance with the Terms of MOU				
		3. Ratio of supervisor to students				
		4. Log books				
		5. Assessment reports				
		6. Training timetable, continuing medical education and attendances list.				
	Facility Comments:					
11.2.1.13	Where Facility has responsibilities in teaching and research, the staff cooperate and participate in these programmes as required.					
	EVIDENCE OF COMPLIANCE	1. Attendance list at teaching workshops				
		2. List of research papers				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
SURVEY ITEM &SELF-ASSESSMENT					
<u>TOPIC 11.3:</u>	<u>POLICIES AND PROCEDURES</u>				
<u>STANDARD 11.3.1</u>	<i>There are written and dated policies and procedures for all the activities of the Operating Suite Services. These policies and procedures reflect the current standards of operating suite practice, relevant regulations, statutory requirements, and the objectives of the services.</i>				
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
11.3.1.1 CORE	There are written policies and procedures for the Operating Suite Services which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated.				
	There is a mechanism for and evidence of a periodic review at least once in every three years.				
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for the service.			
		2. Policies and procedures are consistent with regulatory requirements and current standard practices.			
		3. Evidence of periodic review of policies and procedures.			
		4. The policies and procedures are endorsed and dated.			
	Facility Comments:				
11.3.1.2	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved. These policies and procedures are consistent with current international standards for perioperative care				
	Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.					
		2. Minutes of meeting with evidence of cross reference with other departments					
		3. Documented cross departmental policies					
		4. Evidence that policies and procedures are consistent with current international standards of perioperative care.					
	Facility Comments:						
11.3.1.3	Current policies and procedures are communicated to all staff.						
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings					
		2. Circulation list and acknowledgement					
	Facility Comments:						
11.3.1.4 CORE	There is evidence of compliance with policies and procedures.						
	EVIDENCE OF COMPLIANCE	1.Compliance with policies and procedures through:					
		a) interview of staff on practices;					
		b) verify with observation on practices;					
		c) results of audit on practices i.e. Safe Surgery Saves Lives (SSSL) initiatives;					
		d) practices not in line with established policies and procedures noted from incident reports.					
	Facility Comments:						

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
11.3.1.5	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.			
	EVIDENCE OF COMPLIANCE 1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.			
	Facility Comments:			
11.3.1.6 CORE	Written policies and procedures include the following: a) booking system for all cases; b) development of guidelines to ensure patient and staff safety which include: i) patient transport; ii) patient positioning; iii) drug administration and errors; iv) handling and disposal of sharps; v) prevention of electrical hazards; vi) prevention of fire and explosion; vii) prevention of anaesthetic equipment hazards; viii) maintenance of scavenging equipment for removal of various vapours and anaesthetic gases; ix) notification of biohazards; x) prevention of radiation hazards; c) compliance to World Health Organization (WHO) Patient Safety, 'Safe Surgery Saves Lives', safety checklist - "Time out". d) patient identification, with the nature and site of the operation marked and verified by the surgeon and the consent documents checked.; e) infection control procedures, including aseptic technique, routine and terminal			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	cleaning, and procedures for infectious patients;				
	f) counting procedures for accountable items including the procedures to be adopted in the event of incorrect counts;				
	g) patient management during recovery from anaesthesia and surgery;				
	h) the role of the Operating Suite Services in the fire and disaster plans of the Facility;				
	i) priorities in the use of operating suite time and space;				
	j) “Group Cross Match” and “Screen and hold” policy for blood transfusion practices for patients undergoing surgery;				
	k) clear communication lines for obtaining emergency blood and blood products for cases of unexpected haemorrhage.				
	l) Clear written policies and procedure for the involvement of vendor in providing specialized equipment/consumables for patient care in the operation theater where applicable				
EVIDENCE OF COMPLIANCE	1. Policies and procedures include all but not limited to the elements listed in (a) to (k).				
	2. Documentation that Safe Surgery Saves Lives activities have been carried out and shortfalls discussed with actions taken.				
	3. Policy on when to open a second emergency operating theatre, i.e. prioritisation for emergency surgery.				
Facility Comments:					

SURVEY ITEM &SELF-ASSESSMENT					
TOPIC 11.4: <u>FACILITIES AND EQUIPMENT</u>					
STANDARD 11.4.1 <i>There are adequate physical facilities and equipment for the safe and efficient functioning of the Operating Suite Services.</i>					
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
11.4.1.1	The design of the Operating Suite Services provides adequate space for the reception, anaesthesia induction, surgery, post-surgical recovery and observation of patients. This shall include: a) suitable areas for reception and for patients awaiting surgery; b) operating theatres; c) recovery area; d) adequate storage space for equipment, surgical supplies, linen, housekeeping equipment, and pharmaceutical supplies, including dangerous and psychotropic drugs; e) areas for administrative office, and where required, teaching facilities; f) areas for the collection and disposal of used equipment and waste; g) male and female staff change rooms; h) staff facilities like tea room, locker area, on-call room; i) there is plan for providing improved staff facilities when the Facility undergoes refurbishment or redevelopment if any of the above are deemed inadequate.				
	EVIDENCE OF COMPLIANCE	1. The design and layout of the Operating Suite Services provide adequate space and includes features as listed in (a) to (i).			
		2. Where the Post-Anaesthesia Care Unit (PACU) is located for patients requiring ventilation and critical care, there is a policy for staffing, ventilation and monitoring of the patient.			
	Facility Comments:				
11.4.1.2	The design of the Operating Suite Services supports efficient systems for the management of perioperative services which include:				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	a) operating rooms are treated as “clean” rooms with yearly performance test undertaken to ensure “clean” room status is maintained;			
	b) fire detection, alarm, and suppression systems; firefighting equipment and appropriate sign posting;			
	c) ventilation system should provide positive pressure from the cleanest areas to less clean area;			
	d) definitive traffic flow patterns and demarcation of sterile and non-sterile zones which enable enforcement of sterility discipline;			
	e) ready access for routing emergency patients;			
	f) adequate means of egress from the operating suite in the event of fire;			
	g) free movement of patient trolleys throughout the suite with a minimum of cross traffic;			
h) reception of the patient in close proximity to the junction of sterile and non-sterile zones (air-lock zone);				
i) uninterrupted power supply (UPS) system in operating theatres shall be provided with an alarm system at the reception counter which will be triggered when the system is not charged;				
j) the medical gas system in the operating theatres shall be monitored to ensure that it is functioning;				
k) the quantity of medical gas terminal units be sufficient as required under national and international standards;				
l) colour coding for electrical outlets shall be according to international standards.				
EVIDENCE OF COMPLIANCE	1. The design and layout of the Operating Suite Services provide adequate space and includes features as listed in (a) to (l)			
	2. Internal air quality report (IAQ) report, i.e. temperature and humidity confirms to relevant standards.			
	3. Fire escape plan clearly posted.			
	4. Verification of the appropriateness of the design of the operating suite by onsite inspection.			
	5. Log book on medical gas monitoring			
Facility Comments:				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
11.4.1.3	The requirements for other systems to support perioperative services include: a) adequate numbers of general power outlets distributed according to needs of each area; b) adequate provision for emergency power outlets for lighting and suction of an appropriate nature complying with current Malaysian Standards; c) suitable lighting; d) adequate medical gas and suction supplies complying with current Malaysian Standards; e) a means of environmental control of temperature and humidity within safe limits for anaesthetised patients undergoing surgery/procedures. Note: Environmental control shall ensure that air quality complies with relevant standards for various treatment or functional areas in respect of temperature, relative humidity and particle count.					
	EVIDENCE OF COMPLIANCE				1. Verification of other support systems in the operating suite includes items listed (a) to (e).	
					2. Evidence of minimum of two suction ports (one for anaesthesia and one for surgeon) per operating room. (If inadequate, then there must be portable suction devices for operating theatre needs)	
					3. Temperature maintained at 18°C - 22°C and relative humidity 50% - 60%.	
	Facility Comments:					
11.4.1.4	The Operating Suite Services shall comply with all safety features in accordance with regulatory requirements which include:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	a) compliance with electrical standards for cardiac-protected or body-protected electrical areas, where required. In critical life support applications where loss of power supply cannot be tolerated, special power outlets powered by isolation transformers Line Isolation and Overload Monitor (LIOM) are installed;				
	b) scavenging of anesthetic gases and vapors;				
	c) regular maintenance and monitoring of facilities and equipment, and a system to respond immediately to breakdown, repair, and replacement;				
	d) electrical equipment which comply with Malaysian Standards;				
	e) appropriate shielding and protective clothing are provided in the presence of biohazards or radiographic equipment.				
	Note: Body Protection means basically that every power point needs to be protected by 10milli amp R.C.D.'s or a safety switch which is the same as in most houses but more sensitive to earth leakage currents. This includes dental chairs and X-ray machines.				
	EVIDENCE OF COMPLIANCE				1. The operating theatre complies with all safety features in accordance to regulatory requirements as addressed in (a) to (e).
2. Verification of the above through on-site inspection.					
3. Warning signs if radiology equipment is in use.					
4. If operating theatre is not lead-lined, there must be adequate protective shields available.					
Facility Comments:					
11.4.1.5 CORE	The requirements for equipment used in the Operating Suite Services shall include the following: a) a range of basic and general surgical equipment in quantities sufficient to support the surgical programme;				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	b) where specialised equipment appropriate to the surgical procedure is provided by the surgeon, such equipment shall have prior approval by the Person In Charge (PIC) of the Facility and shall be checked to comply with the relevant safety requirements and be appropriately sterilised before use; c) minimum standards for monitoring in anaesthesia as defined by the Malaysian Society of Anaesthesiologists or the College of Anaesthesiologists of the Academy of Medicine of Malaysia (current edition); d) emergency and resuscitation equipment and supplies; with clearly defined instructions on how to operate the equipment and there is evidence that staff are trained to use the equipment; e) availability of point of care testing equipment for urgent laboratory tests (e.g. Arterial Blood Gas investigation) OR process to ensure that results of such tests sent to the laboratory can be reported immediately; f) there shall be a blood refrigerator or alternative storage facilities for group and cross matched blood in the operating room.				
	EVIDENCE OF COMPLIANCE	1. The requirements for equipment used in the Operating Suite Services shall include items (a) to (f). 2. Verification of above through on-site inspection 3. Policy on handling and maintenance of borrowed equipment 4. Resuscitation drugs and equipment are in accordance to "Recommendations for Patient Safety and Minimal Monitoring Standards during Anaesthesia and Recovery" (Current Edition).			
	Facility Comments:				
11.4.1.6	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.				
	EVIDENCE OF COMPLIANCE	1. Testing, commissioning and calibration records (certificates or stickers) 2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc. as evidence of compliance to the relevant standards and Acts.			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
11.4.1.7	Emergency biomedical equipment is thoroughly tested as a routine, e.g. defibrillators are discharged and output checked every day or after each use, and the results recorded.					
	EVIDENCE OF COMPLIANCE	1. Records on regular inspection and checking biomedical equipment (electrocardiogram strips for defibrillator)				
		2. Policy and schedule on checking biomedical equipment				
	Facility Comments:					
11.4.1.8 CORE	There is evidence that the facility has a comprehensive maintenance programmed such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.					
	EVIDENCE OF COMPLIANCE	1. Planned Preventive Maintenance records such as schedule, stickers, etc.				
		2. Planned Replacement Programme where applicable				
		3. Complaint records				
		4. Asset inventory				
	Facility Comments:					
11.4.1.9	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.					
	EVIDENCE OF COMPLIANCE	1. User training records				
		2. Competency assessment record				
		3. Letter of authorisation				
		4. List of staff trained and authorised to operate specialised equipment				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 11.5:		<u>SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES</u>				
STANDARD <u>11.5.1</u>		<i>The Head of the Operating Suite Services shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Operating Suite Services. The Head of Operating Suite Services shall ensure compliance to monitoring of specific performance indicators.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
11.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Operating Suite Services. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.					
	EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to (f)				
		2. Records on performance improvement activities.				
		3. Minutes of performance improvement meetings				
		4. Performance improvement studies				
		5. Mortality and morbidity audits with remedial actions				
		6. Records on innovation if available				
	Facility Comments:					
11.5.1.2	The Head of Operating Suite Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement to appropriate individual/personnel within the respective services.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes of meetings				
		2. Letter of assignment of responsibilities				
		3. Job description				
	Facility Comments:					
11.5.1.3	The Head of the Operating Suite Services shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility.					
	Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.					
	EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:				
		a) Training of staff				
		b) Policy on incident reporting				
		c) Methodology of incident reporting				
		d) Register/records of incidents				
		2. Completed incident reports				
		3. Root Cause Analysis				
		4. Corrective and preventive action plans				
		5. Remedial measure				
		6. Minutes of meetings				
		7. Acknowledgment by Head of Service and PIC/Hospital Director				
		8. Feedback given to staff regarding incident reporting.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
11.5.1.4 CORE	There is tracking and trending of specific performance indicators not limited to but at least of the following, a minimum of 5 indicators:			
	a) <u>Mandatory indicator</u> compliance to Safe Surgery Saves Lives (SSSL) practice			
	b) elective operation cancellation rate (Target: <10%)			
	c) percentage of patients awaiting emergency surgery for more than 24 hours due to lack of theatre time (Target: <1%);			
	d) number of patients returning to surgery within 24 hours (sentinel event)			
	e) time taken for lower segment caesarean section (LSCS) for fetal distress within 30 minutes of informing operating theatre (sentinel event)			
	f) number of unnecessary delay in starting surgery after induction of anaesthesia due to lack of personnel or equipment (sentinel event)			
g) number of incidents reported in the operating room				
h) number of peri-operative mortality and morbidity review				
i) percentage of cases done as day care or day of surgery admission (DOSA) (30% of all surgeries)				
EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored.			
	2. Records on tracking and trending analysis.			
	3. Minutes of mortality/morbidity audits meetings			
	4. Remedial measures taken where appropriate			
Facility Comments:				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS				
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING			
11.5.1.5	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.								
	EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff.							
		2. Evidence of feedback via communication on results of performance improvement activities through continuing medical education/meetings.							
		3. Minutes of service/committee meetings							
	Facility Comments:								
11.5.1.6	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.								
	EVIDENCE OF COMPLIANCE	1. Documentation on performance improvement activities and performance indicators.							
		2. Policy statement on anonymity on patients and providers involved in performance improvement activities.							
	Facility Comments:								

SURVEYOR SUMMARY:

OVERALL RISK:

SURVEY ITEM & SELF-ASSESSMENT				
SERVICE STANDARD 12 : AMBULATORY CARE SERVICES				
	<u>PREAMBLE</u> <i>Ambulatory care is defined as scheduled procedures provided to patients who do not require hospital stay overnight. It is a process of care where suitable patients are managed with admission, treatment and discharge on the same day. Ambulatory care is done for diagnostic and therapeutic procedures which may require local, regional, or general anaesthesia, minimal or do not carry risk of post-operative complications but require a period of observation in the Facility.</i> <i>There are guidelines to specify which patients can be treated, which procedures and under what form of anaesthesia/sedation can be performed as ambulatory care. The service could also include patients treated and managed in the day care for medical conditions, diagnostic and interventional procedures, such as the endoscopic services.</i>			
<u>TOPIC 12.1:</u> <u>STANDARD 12.1.1</u>	<u>ORGANISATION AND MANAGEMENT</u> <i>The Ambulatory Care Services are organised to provide safe and efficient care for ambulatory patients. The Ambulatory Care Services are coordinated with other departments and services of the Facility. The service could also include patients treated and managed in the day care for medical conditions, diagnostic and interventional procedures, such as the endoscopic services. Patients receiving chemotherapy should be treated in a designated area.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
12.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Ambulatory Care Services are clearly documented and measurable that indicates safety, quality and patient centred care. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.				
		2. Goals and objectives of the Ambulatory Care Services in line with the Facility statements are available, endorsed and dated.				
		3. Evidence of planned reviews of the above statements.				
		4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)				
		5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.				
	Facility Comments:					
12.1.1.2 CORE	There is an organisation chart which: a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head of the Ambulatory Care Services, consultants, medical practitioners and staff of the Ambulatory Care Services; b) to all staff and clients; c) includes off-site services if applicable; d) is revised when there is a major change in any one of the following: i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns.					
EVIDENCE OF COMPLIANCE	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head of the Ambulatory Care Services, consultants, medical practitioners and staff of the Ambulatory Care Services.					
	2. Organisation chart of the service is endorsed, dated and accessible.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).				
	Facility Comments:					
12.1.1.3	The Governing Body shall ensure that Ambulatory Care Services are organised in such a way as to: a) facilitate the provision of ambulatory care services to patients in the Facility in a safe, efficient, effective, and caring manner and with due regard for the needs, dignity and privacy of patients and confidentiality of their personal information; b) assure continuity of care; c) address the professional needs of the medical practitioners; d) ensure that the medical practitioners are involved in the formulation of policies and procedures concerning patient care appropriate to the scope of services of the Facility.					
	EVIDENCE OF COMPLIANCE	1. Departmental/Service operational policies that address (a) to (d).				
		2. Medical Staff By-Laws				
		3. Evidence of involvement of medical practitioners in the formulation of policies and procedures concerning patient care.				
		4. Involvement of Head of the Service in the Medical and Dental Advisory Committee/Medical Advisory Committee and ward meetings.				
		5. Minutes of meetings				
		6. Proper and adequate equipment according to current standards.				
	Facility Comments:					
12.1.1.4 CORE	The Head of Ambulatory Care Services has:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	a) representation of the Service in committees where applicable, e.g. Operating Theatre Committee, Blood Transfusion Committee, etc and subcommittees where relevant;					
	b) representation of the Service in clinical staff liaison meetings;					
	c) involvement and provide regular input to the Senior Management Team.					
	EVIDENCE OF COMPLIANCE				1. Letter of appointment and delineation of duties and responsibilities of the Head of the Service.	
					2. Letter of appointment and Terms of Reference as member of the Medical and Dental Advisory Committee/Medical Advisory Committee	
					3. Minutes of meetings of Medical and Dental Advisory Committee/Medical Advisory Committee/Management	
					4. Letter of appointment for representation in relevant committees, e.g. Operating Theatre Committee and minutes of meetings.	
Facility Comments:						
12.1.1.5	Regular staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Ambulatory Care Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.					
	EVIDENCE OF COMPLIANCE				1. Minutes are accessible, disseminated and acknowledged by the staff.	
					2. Attendance list of members with adequate representatives of the service.	
					3. Frequency of meetings as scheduled.	
					4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).	
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
12.1.1.6	The Head of the Ambulatory Care Services is involved in the planning, justification and management of the budget and resource utilisation of the services.					
	EVIDENCE OF COMPLIANCE	1. Minutes of Facility-wide management meeting				
		2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service.				
		3. Approved budget and resources.				
	Facility Comments:					
12.1.1.7	The Head of the Ambulatory Care Services is involved in the appointment and/OR assignment of staff.					
	EVIDENCE OF COMPLIANCE	1. Records on staff interview (if applicable)				
		2. Appointment/assignment letter of Head of Service				
		3. Job description of Head of Service				
		4. Records on staff deployment				
		5. Duty roster				
	Facility Comments:					
12.1.1.8	Ambulatory Care Services are provided appropriate to the Facility's scope of medical and surgical services.					
	EVIDENCE OF COMPLIANCE	1. List of ambulatory care services provided				
		2. Patient registration records				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
12.1.1.9	Appropriate statistics and records shall be maintained in relation to the provision of Ambulatory Care Services and used for managing the services and patient care purposes.				
	EVIDENCE OF COMPLIANCE	1. Records are available but not limited to the following:			
		a) workload/census;			
		b) annual report;			
		c) accident/incident reports;			
		d) staffing number and staff profile;			
		e) staff training records;			
	f) data on performance improvement activities, including performance indicators.				
Facility Comments:					
12.1.1.10	Appropriate records are maintained by the Ambulatory Care Services which are adequate for clinical, medicolegal, and evaluation purposes and include the following:				
	a) a record of medical practitioners conferred the privileges of performing specific procedures is displayed, available and accessible to all staff;				
	b) a register of operations/procedures performed within the Ambulatory Care Services is maintained;				
	c) a record of the procedure performed is filed in the patient's medical record;				
	d) standard drug administration records are maintained and regulations relating to the control of drugs are followed;				
e) documented evidence of the counting of accountable items used in the procedures (including operating theatre) and a copy of this is included in the patient's medical record.					
EVIDENCE OF COMPLIANCE	1. Records maintained by Ambulatory Care Services include (a) to (e).				
	2. Privileges of clinical staff performing specific procedures is available at point of care				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
		3. Record of the procedure performed and documented in the patient's medical record details the followings:				
		a) procedure performed;				
		b) date and time;				
		c) type of anaesthesia;				
		d) personnel involved in the procedure;				
		e) findings;				
		f) record of accountable items used in operating theatre;				
		g) the dressings applied and drainage systems inserted (where applicable);				
		h) postoperative orders;				
	i) discharge and follow up notes.					
Facility Comments:						
12.1.1.11 CORE	Clinical staff performs within the privileges conferred.					
	EVIDENCE OF COMPLIANCE	1. Verification of procedures e.g. setting long lines performed by individual at point of care within the awarded privileging rights with evidence of:				
		a) list of procedures privileged;				
		b) clinical notes.				
	Facility Comments:					
12.1.1.12	Support services such as pharmacy, radiology, pathology and blood bank are available as appropriate, and effective communication and relationship with these services are maintained.					
	EVIDENCE OF COMPLIANCE	1. Availability of relevant clinical support services				
		2. Floor plan indicates accessibility to supporting services.				
		3. Appropriate telecommunication modalities and system.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT								
TOPIC 12.2		<u>HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT</u>						
STANDARD 12.2.1		<i>The Ambulatory Care Services shall be directed by a qualified and competent medical practitioner, and staffed by suitably qualified and competent clinical staff to achieve the goals and objectives of the services. Staff of the services have access to appropriate education programmes to maintain and improve their knowledge and skills.</i>						
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS				
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING			
12.2.1.1	The Head and staff of the Ambulatory Care Services shall be individuals qualified by education, training, experience and certification to commensurate with the requirements of the various positions.							
	EVIDENCE OF COMPLIANCE	1. Records on credentials of Head of Service and staff required to fill up the posts within the service (to match the complexity of the Facility and services) and certification/registration.						
		2. Appointment/assignment letter						
		3. Training and competency records						
	Facility Comments:							
12.2.1.2	The authority, responsibilities and accountabilities of the Head of Ambulatory Care Services are clearly delineated and documented.							
	EVIDENCE OF COMPLIANCE	1. Appointment/assignment letter for Head of Service.						
		2. Description of duties and responsibilities						
	Facility Comments:							

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
12.2.1.3	Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the need of the services.					
	EVIDENCE OF COMPLIANCE	1. Number of staff and qualification should commensurate with workload.				
		2. Staffing pattern				
		3. Duty roster				
		4. Census and statistics				
	Facility Comments:					
12.2.1.4	There are written and dated specific job descriptions for all categories of staff that include: a) qualifications, training, experience and certification required for the position; b) lines of authority; c) accountability, functions and responsibilities; d) reviewed when required and when there is a major change in one of the following: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations. e) administrative and clinical functions.					
	EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e).				
		2. Job description includes specialisation skills				
		3. Relevant privileges granted where applicable				
		4. The job description is acknowledged by the staff and signed by the Head of Service and dated.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
12.2.1.5	Personnel records on training, staff development, leave and others are maintained for every staff.					
	Note: Staff personal record may be kept in Human Resource Department as per Facility policy.					
	EVIDENCE OF COMPLIANCE				1. Staff personal records include:	
					a) staff biodata;	
					b) qualification and experience;	
					c) evidence of current registration;	
					d) training record;	
					e) competency record and privileging;	
					f) leave record;	
	g) confidentiality agreement.					
Facility Comments:						
12.2.1.6	There is a structured orientation programme for all newly appointed staff to the Ambulatory Care Services including medical practitioners and for those new to specific areas that include the following:					
	a) explanation of the goals, objectives, policies and procedures of the Facility and those of the Ambulatory Care Services;					
	b) lines of authority and areas of responsibility;					
	c) explanation of particular duties and functions;					
	d) explanation of the methods of assigning clinical care and the standards of clinical practice;					
	e) handover communication;					
	f) processes for resolving practice dilemmas;					
	g) information about safety procedures;					
	h) training in basic/advanced life support techniques;					
	i) methods of obtaining appropriate resource materials;					
j) staff appraisal procedures for the Ambulatory Care Services;						
k) education on Patient and Family Rights;						
l) education on MSQH Standards requirements.						

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme.				
		2. There is Ambulatory Care Services orientation programme with relevant topics not limited to topics covered from (a) to (l).				
		3. Attendance list				
	Facility Comments:					
12.2.1.7	There is evidence of training needs assessment and staff development plan which provides the knowledge and skills required for staff to maintain competency in their current positions and future advancement.					
	EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and gaps identified.				
		2. A staff development plan based on training needs assessment is available.				
		3. Training schedule/calendar is in place.				
		4. Training module				
	Facility Comments:					
12.2.1.8	There are continuing education activities for staff including medical practitioners to pursue professional interests and to prepare for current and future changes in practice.					
	EVIDENCE OF COMPLIANCE	1. Training calendar includes in-house/external courses/workshop/conferences				
		2. Contents of training programme				
		3. Training records on continuing education activities are kept and maintained for each staff including training in life support.				
		4. Certificate of attendance/degree/post basic training				
	Facility Comments:					
12.2.1.9	Staff including medical practitioners receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff including medical practitioners is completed upon probationary period and as an annual exercise.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 12.3:		<u>POLICIES AND PROCEDURES</u>				
STANDARD <u>12.3.1</u>		<i>Documented policies and procedures shall reflect current knowledge and practice for the ambulatory care services, and they are consistent with statutory requirements and the goals and objectives of the Ambulatory Care Services.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
12.3.1.1 CORE	There are written policies and procedures for the Ambulatory Care Services which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated.					
	There is a mechanism for and evidence of a periodic review at least once in every three years.					
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for the service.				
		2. Policies and procedures are consistent with the regulatory requirements and current standard practices.				
		3. Evidence of periodic review of policies and procedures.				
		4. The policies and procedures are endorsed and dated.				
Facility Comments:						
12.3.1.2	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved.					
	Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.					
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.				
		2. Minutes of meeting with evidence of cross reference with other departments				
3. Documented cross departmental policies						

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	Facility Comments:				
12.3.1.3	Current policies and procedures are communicated to all staff.				
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings			
		2. Circulation list and acknowledgement			
	Facility Comments:				
12.3.1.4 CORE	There is evidence of compliance with policies and procedures.				
	EVIDENCE OF COMPLIANCE	1. Compliance with policies and procedures through:			
		a) interview of staff on practices;			
		b) verify with observation on practices;			
		c) results of audit on practices;			
		d) practices in line with established policies and procedures.			
	Facility Comments:				
12.3.1.5	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.				
	EVIDENCE OF COMPLIANCE	1. Copies of relevant policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.			
	Facility Comments:				
12.3.1.6 CORE	Documented policies of a planned systematic approach to the provision of ambulatory patient care. These include:				
	a) available criteria for selection and assessment of cases;				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	b) policy on the use of sedation during procedures; c) documented admission policies including age or disease limitations and the restrictions concerning the scope of clinical services offered; d) the booking and admission of patients comply with admission policies; e) essential information on the service is given to all patients that outlines: i) the patient's pre-admission responsibilities and preparation; ii) the functioning of the Ambulatory Care Services; iii) type of anaesthesia and postanaesthetic effects; iv) provision for after-hours contact and emergency care; v) patient's post-discharge responsibilities/home care instructions. f) the requirements for a preanaesthetic assessment to be performed by a medical practitioner; g) patient identification, with the nature and site of the procedure marked and verified by the surgeon and the consent documents checked; h) observations of the patient's pre-, intra- ,and post-procedure status and vital signs are monitored and recorded in the medical record; i) a dedicated anaesthetist is present or readily available until all patients who have undergone anaesthesia/sedation are discharged; j) the discharge procedure ensures the patient is given relevant documented postoperative instructions and there is a responsible person/family members accompanying the discharged patient. The address and phone number of the discharge person/family members are recorded in the medical record. EVIDENCE OF COMPLIANCE 1. Documented policies that address (a) to (j). Facility Comments:			
12.3.1.7	All patients and their relatives shall be given essential information pertaining to the procedure which include: a) the patient's pre-admission responsibilities and preparation; b) the functioning of the Ambulatory Care Services;			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	c) type of anaesthesia and post anaesthetic effects; d) provision for after-hours contact and emergency care; e) the patient's post-discharge responsibilities/instructions.					
	EVIDENCE OF COMPLIANCE	1. Patients and relatives given adequate information on the procedure carried out as evidenced by :				
		a) patient information pamphlet;				
		b) relevant contact number for any emergency care;				
		c) written post-operative instructions;				
		d) written follow up instruction.				
	Facility Comments:					
12.3.1.8	The policies and procedures for management of emergency patients shall include arrangement for transfer of patients, where necessary.					
	EVIDENCE OF COMPLIANCE	1. Policies and procedures on management of emergency patients include:				
		a) patient transfer;				
		b) referral details including notes on patient's medical history.				
		2. Verification on compliance as per patient notes on transfer arrangement.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 12.4:		<u>FACILITIES AND EQUIPMENT</u>				
STANDARD 12.4.1		<i>There are adequate physical facilities and equipment for safe and efficient functioning of the Ambulatory Care Services. The services may operate from a purpose-built facility with designated rooms such as those used for endoscopy, oncological purposes or from the main Operating Suite Services.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
12.4.1.1	There are adequate and appropriate facilities and equipment with proper utilisation of space to enable staff to carry out their professional, teaching and administrative functions.					
	EVIDENCE OF COMPLIANCE	1. Facilities for Ambulatory Care Services include the following:				
		a) adequate working space with suitable lighting;				
		b) storage space for equipment, surgical supplies, linen, housekeeping equipment, and pharmaceutical supplies, including the storage of dangerous and psychotropic drugs;				
		c) easy access;				
		d) facilities for disabled persons;				
		e) vehicle access to facilitate the safe admission and discharge of patients;				
		f) adequate provision for emergency power and uninterrupted power supply (UPS) where indicated.				
		g) adequate facilities and equipment at each patient care area for safe care. (e.g. defibrillators, emergency cart, hand washing facilities etc)				
	Facility Comments:					
12.4.1.2	Equipment, both for emergency and non-emergency usage, shall be appropriate to the level of care.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Availability of emergency and non-emergency equipment appropriate to level of care, such as defibrillator, emergency trolley, suction machine, electrocardiogram (ECG) machine, infusion or syringe pump, vital signs monitor, etc				
		2. Proper cleaning / washing facilities for equipment				
		3. Proper sterilisation and storage facilities for endoscopes				
		4. Adequate medical gas and suction supplies				
		5. Fire extinguishers at relevant areas				
		6. Scheduled checking of items in emergency trolley				
	Facility Comments:					
12.4.1.3	The Ambulatory Care Services shall comply with all safety features in accordance with regulatory requirements which include: a) electrical equipment complies with relevant electrical standards on the safe use of electricity in patient care; b) staff are aware of the appropriate procedures in the safe use and application of electromedical equipment; c) regular maintenance and monitoring of facilities and equipment, and a system to respond to breakdown repair and replacement; d) emergency biomedical equipment, e.g. defibrillator is checked at least once a day or after each use and the result is recorded; e) equipment complies with relevant standards, e.g. those set by Standards and Industrial Research Institute of Malaysia (SIRIM) and current statutory requirements.					
EVIDENCE OF COMPLIANCE	1. Certification or label of safety standards for equipment as required by law.					
	2. Awareness training of staff on use of and application of electromedical equipment.					
	3. Planned Preventive Maintenance (PPM), calibration and repair records					
	4. Defibrillator calibration testing record					
Facility Comments:						

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
12.4.1.4	Where specialised equipment is provided by the attending medical practitioner, such equipment shall have the prior approval by the Person In Charge (PIC) of the Facility and should be checked to comply with the relevant safety requirements and be appropriately sterilised before use.					
	EVIDENCE OF COMPLIANCE	1. Policy on equipment provided by the attending medical practitioner including safety and sterilisation requirements.				
		2. Letter of approval by PIC on use of equipment provided by attending practitioner.				
		3. Planned Preventive Maintenance (PPM), calibration and repair records.				
	Facility Comments:					
12.4.1.5	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.					
	EVIDENCE OF COMPLIANCE	1. Testing, commissioning and calibration records (certificates or stickers)				
		2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as evidence of compliance to the relevant standards and Acts.				
	Facility Comments:					
12.4.1.6 CORE	There is evidence that the facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.					
	EVIDENCE OF COMPLIANCE	1. Planned Preventive Maintenance records such as schedule, stickers, etc.				
		2. Planned Replacement Programme where applicable				
		3. Complaint records				
		4. Asset inventory				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
12.4.1.7	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.					
	EVIDENCE OF COMPLIANCE	1. User training records				
		2. Competency assessment record				
		3. Letter of authorisation				
		4. List of staff trained and competent to operate specialised equipment				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 12.5:		<u>SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES</u>				
STANDARD 12.5.1		<i>The Head of Ambulatory Care Services shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Ambulatory Care Services. The Head of Ambulatory Care Services shall ensure compliance to monitoring of specific performance indicators.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
12.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Ambulatory Care Services. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.					
	EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to (f)				
		2. Records on performance improvement activities				
		3. Minutes of performance improvement meetings				
		4. Performance improvement studies				
		5. Mortality and morbidity audits with remedial actions				
		6. Records on innovation if available.				
	Facility Comments:					
12.5.1.2	The Head of Ambulatory Care Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement activities to appropriate individual/personnel within the respective services.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes of meetings				
		2. Letter of assignment of responsibilities				
		3. Job description				
	Facility Comments:					
12.5.1.3	The Head of the Ambulatory Care Services shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility.					
	Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.					
	EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:				
		a) Training of staff				
		b) Policy on incident reporting				
		c) Methodology of incident reporting				
		d) Register/records of incidents				
		2. Completed incident reports				
		3. Root Cause Analysis				
		4. Corrective and preventive action plans				
		5. Remedial measure				
		6. Minutes of meetings				
		7. Acknowledgment by Head of Service and PIC/Hospital Director				
		8. Feedback given to staff regarding incident reporting.				
	Facility Comments:					
12.5.1.4 CORE	There is tracking and trending of specific performance indicators not limited to but at least two (2) of the following:					
	a) unplanned admissions of ambulatory care patients as inpatients. (sentinel event)					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	b) cancellation rate of ambulatory care cases					
	EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored.				
		2. Records on tracking and trending analysis.				
		3. Remedial measures taken where appropriate.				
	Facility Comments:					
12.5.1.5	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.					
	EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff.				
		2. Evidence of feedback via communication on results of performance improvement activities through continuing medical education/meetings.				
		3. Minutes of service/unit/committee meetings				
	Facility Comments:					
12.5.1.6	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.					
	EVIDENCE OF COMPLIANCE	1. Documentation on performance improvement activities and performance indicators.				
		2. Policy statement on anonymity on patients and providers involved in performance improvement activities.				
	Facility Comments:					

SERVICE SUMMARY	
SURVEYOR SUMMARY:	
OVERALL RATING:	
OVERALL RISK:	

SURVEY ITEM & SELF-ASSESSMENT				
SERVICE STANDARD 12A : AMBULATORY CARE SERVICES – ENDOSCOPY SERVICES				
	<u>PREAMBLE</u> <i>Ambulatory Endoscopy care is defined as Clinical services, scheduled, and completed in the same day (same calendar day) and does not require the patient to stay overnight in the hospital. The services should include 4 criteria:</i> <i>1. The patient are scheduled / elective) to undergo treatment</i> <i>2. The scheduled Procedures have been done</i> <i>3. Procedures carried out required a short recovery period together with the complete documentation in the progress of the patient during the observation period.</i> <i>4. Patients discharge from observation ward in the same calendar day.</i> <i>Ambulatory endoscopy care is done for diagnostic, and therapeutic procedures which require local, sedation or General Anesthesia which do not carry the risk of post operative complications but require a period of observation in the observation ward.</i>			
<u>TOPIC 12A.1:</u> <u>STANDARD 12A.1.1</u>	<u>ORGANISATION AND MANAGEMENT</u> <i>The Ambulatory Endoscopy Services are organised to provide safe and efficient care for ambulatory endoscopy patients. The Ambulatory Endoscopy Services are coordinated with other departments and services of the Facility. The service could also include patients treated and managed in the day care for medical conditions, diagnostic and interventional procedures.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
12A.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Ambulatory Endoscopy Services are clearly documented and measurable that indicates safety, quality and patient centred care. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.				
		2. Goals and objectives of the Ambulatory Endoscopy Services in line with the Facility statements are available, endorsed and dated.				
		4. Evidence of planned reviews of the above statements.				
		5. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)				
		6. Achievement of goals and objectives are monitored, reviewed and revised accordingly.				
	Facility Comments:					
12A.1.1.2 CORE	There is an organisation chart which: a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head of the Ambulatory Care Services, consultants, medical practitioners and staff of the Ambulatory Care Services; b) to all staff and clients; c) includes off-site services if applicable; d) is revised when there is a major change in any one of the following: i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns.					
	EVIDENCE OF COMPLIANCE	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head of the Ambulatory Care Services, consultants, medical practitioners and staff of the Ambulatory Care Services.				
		2. Organisation chart of the service is endorsed, dated and accessible.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).				
	Facility Comments:					
12A.1.1.3	The Governing Body shall ensure that Ambulatory Endoscopy Services are organised in such a way as to: a) facilitate the provision of ambulatory Endoscopy services to patients in the Facility in a safe, efficient, effective, and caring manner and with due regard for the needs, dignity and privacy of patients and confidentiality of their personal information; b) assure continuity of care; c) address the professional needs of the medical practitioners; d) ensure that the medical practitioners are involved in the formulation of policies and procedures concerning patient care appropriate to the scope of services of the Facility.					
	EVIDENCE OF COMPLIANCE	1. Departmental/Service operational policies that address (a) to (d).				
		2. Medical Staff By-Laws				
		3. Evidence of involvement of medical practitioners in the formulation of policies and procedures concerning patient				
		4. Involvement of Head of the Service in the Medical and Dental Advisory Committee/Medical Advisory Committee and ward meetings.				
		5. Minutes of meetings				
		6. Proper and adequate equipment according to current standards.				
	Facility Comments:					
12A.1.1.4 CORE	The Head of Ambulatory Endoscopy Services has: a) representation of the Service in committees where applicable and subcommittees where relevant.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	b) representation of the Service in clinical staff liaison meetings;					
	c) involvement and provide regular input to the Senior Management Team.					
	EVIDENCE OF COMPLIANCE	1. Letter of appointment and delineation of duties and responsibilities of the Head of the Endoscopy Service.				
		2. Letter of appointment for representation in relevant committees, e.g. Ambulatory Care services.				
	Facility Comments:					
12A.1.1.5	Regular staff meetings are held between the Head of Endoscopy Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Ambulatory Endoscopy Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.					
	EVIDENCE OF COMPLIANCE	1. Minutes are accessible, disseminated and acknowledged by the staff.				
		2. Attendance list of members with adequate representatives of the service.				
		3. Frequency of meetings as scheduled.				
		4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).				
	Facility Comments:					
12A.1.1.6	The Head of the Ambulatory Endoscopy Services is involved in the planning, justification and management of the budget and resource utilisation of the services.					
	EVIDENCE OF COMPLIANCE	1. Minutes of Facility-wide management meeting				
		2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service.				
		3. Approved budget and resources.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS			
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
12A.1.1.7	The Head of the Ambulatory Endoscopy Services is involved in the appointment and /OR assignment of staff.						
	EVIDENCE OF COMPLIANCE	1. Records on staff interview (if applicable)					
		2. Appointment/assignment letter of Head of Endoscopy					
		3. Job description of Head of Endoscopy Service					
		4. Records on staff deployment					
		5. Duty roster					
	Facility Comments:						
12A.1.1.8	Ambulatory Endoscopy Services are provided appropriate to the Facility's scope of medical and surgical services.						
	EVIDENCE OF COMPLIANCE	1. List of ambulatory Endoscopy services provided					
		2. Patient registration records					
	Facility Comments:						
12A.1.1.9	Appropriate statistics and records shall be maintained in relation to the provision of Ambulatory Endoscopy Services and used for managing the services and patient care purposes.						
	EVIDENCE OF COMPLIANCE	1. Records are available but not limited to the following:					
		a) workload/census;					
		b) annual report;					
		c) accident/incident reports;					
		d) staffing number and staff profile;					
		e) staff training records;					
		f) data on performance improvement activities, including performance indicators.					
	Facility Comments:						

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
12A.1.1.10	Appropriate records are maintained by the Ambulatory Endoscopy Services which are adequate for clinical, medicolegal, and evaluation purposes and include the following:				
	a) a record of medical practitioners conferred the privileges of performing specific procedures is displayed, available and accessible to all staff;				
	b) a register of procedures performed within the Ambulatory Endoscopy Services is maintained;				
	c) a record of the procedure performed is filed in the patient's medical record;				
	d) standard drug administration records are maintained and regulations relating to the control of drugs are followed;				
	e) documented evidence of the counting of accountable items used in the procedures (including operating theatre) and a copy of this is included in the patient's medical record.				
	EVIDENCE OF COMPLIANCE	1. Records maintained by Ambulatory Endoscopy Services include (a) to (e).			
		2. Privileges of clinical staff performing specific procedures is available at point of care			
		3. Record of the procedure performed and documented in the patient's medical record details the followings:			
		a) procedure performed;			
		b) date and time;			
		c) type of anaesthesia;			
		d) personnel involved in the procedure;			
		e) findings;			
		f) record of accountable items used in OT / Endoscopy			
		g) the dressings applied and drainage systems inserted (where applicable);			
	h) postoperative orders;				
i) discharge and follow up notes.					
Facility Comments:					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
12A.1.1.11 CORE	Clinical staff performs within the privileges conferred.							
	EVIDENCE OF COMPLIANCE	1. Verification of procedures performed by individual at point of care within the awarded privileging rights with evidence of:						
		a) list of procedures privileged;						
		b) clinical notes.						
	Facility Comments:							
12A.1.1.12	Support services such as pharmacy, radiology, pathology and blood bank are available as appropriate, and effective communication and relationship with these services are maintained.							
	EVIDENCE OF COMPLIANCE	1. Availability of relevant clinical support services						
		2. Floor plan indicates accessibility to supporting services.						
		3. Appropriate telecommunication modalities and system.						
	Facility Comments:							

SURVEY ITEM & SELF-ASSESSMENT								
<u>TOPIC 12A.2</u>		<u>HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT</u>						
<u>STANDARD 12A.2.1</u>		<i>The Ambulatory Endoscopy Services shall be directed by a qualified and competent medical practitioner, and staffed by suitably qualified and competent clinical staff to achieve the goals and objectives of the services. Staff of the services have access to appropriate education programmes to maintain and improve their knowledge and skills.</i>						
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
12A.2.1.1	The Head and staff of the Ambulatory Endoscopy Services shall be individuals qualified by education, training, experience and certification to commensurate with the requirements of the various positions.							
	EVIDENCE OF COMPLIANCE	1. Records on credentials of Head of Endoscopy Service and staff required to fill up the posts within the service (to match the complexity of the Facility and services) and						
		2. Appointment/assignment letter						
		3. Training and competency records						
	Facility Comments:							
12A.2.1.2	The authority, responsibilities and accountabilities of the Head of Ambulatory Endoscopy Services are clearly delineated and documented.							
	EVIDENCE OF COMPLIANCE	1. Appointment/assignment letter for Head of Endoscopy Service.						
		2. Description of duties and responsibilities						
	Facility Comments:							
12A.2.1.3	Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the need of the services.							
	EVIDENCE OF COMPLIANCE	1. Number of staff and qualification should commensurate with workload.						
		2. Staffing pattern						
		3. Duty roster						

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	4. Census and statistics				
	Facility Comments:				
12A.2.1.4	There are written and dated specific job descriptions for all categories of staff that include: a) qualifications, training, experience and certification required for the position; b) lines of authority; c) accountability, functions and responsibilities; d) reviewed when required and when there is a major change in one of the following: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations. e) administrative and clinical functions.				
	EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e).			
		2. Job description includes specialisation skills			
		3. Relevant privileges granted where applicable			
		4. The job description is acknowledged by the staff and signed by the Head of Endoscopy Service and dated.			
	Facility Comments:				
12A.2.1.5	Personnel records on training, staff development, leave and others are maintained for every staff. Note: Staff personal record may be kept in Human Resource Department as per Facility policy.				
	EVIDENCE OF COMPLIANCE	1. Staff personal records include:			
		a) staff biodata;			
		b) qualification and experience;			
		c) evidence of current registration;			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		d) training record;				
		e) competency record and privileging;				
		f) leave record;				
		g) confidentiality agreement.				
	Facility Comments:					
12A.2.1.6	There is a structured orientation programme for all newly appointed staff to the Ambulatory Endoscopy Services including medical practitioners and for those new to specific areas that include the following: a) explanation of the goals, objectives, policies and procedures of the Facility and those of the Ambulatory Endoscopy Services; b) lines of authority and areas of responsibility; c) explanation of particular duties and functions; d) explanation of the methods of assigning clinical care and the standards of clinical practice; e) handover communication; f) processes for resolving practice dilemmas; g) information about safety procedures; h) training in basic/advanced life support techniques; i) methods of obtaining appropriate resource materials; j) staff appraisal procedures for the Ambulatory Care Services; k) education on Patient and Family Rights; l) education on MSQH Standards requirements.					
	EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme.				
		2. There is Ambulatory Endoscopy Services orientation programme with relevant topics not limited to topics covered from (a) to (l).				
		3. Attendance list				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
12A.2.1.7	There is evidence of training needs assessment and staff development plan which provides the knowledge and skills required for staff to maintain competency in their current positions and future advancement.					
	EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and gaps identified.				
		2. A staff development plan based on training needs assessment is available.				
		3. Training schedule/calendar is in place.				
		4. Training module				
	Facility Comments:					
12A.2.1.8	There are continuing education activities for staff including medical practitioners to pursue professional interests and to prepare for current and future changes in practice.					
	EVIDENCE OF COMPLIANCE	1. Training calendar includes in-house/external courses/workshop/conferences				
		2. Contents of training programme				
		3. Training records on continuing education activities are kept and maintained for each staff including training in life support.				
		4. Certificate of attendance/degree/post basic training				
	Facility Comments:					
12A.2.1.9	Staff including medical practitioners receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.					
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff including medical practitioners is completed upon probationary period and as an annual exercise.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
<u>TOPIC 12A.3:</u>		<u>POLICIES AND PROCEDURES</u>				
<u>STANDARD</u> <u>12A.3.1</u>		<i>Documented policies and procedures shall reflect current knowledge and practice for the ambulatory Endoscopy services, and they are consistent with statutory requirements and the goals and objectives of the Ambulatory Endoscopy Services.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
12A.3.1.1 CORE	There are written policies and procedures for the Ambulatory Endoscopy Services which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated. There is a mechanism for and evidence of a periodic review at least once in every five years.					
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for the service.				
		2. Policies and procedures are consistent with the regulatory requirements and current standard practices.				
		3. Evidence of periodic review of policies and procedures.				
		4. The policies and procedures are endorsed and dated.				
	Facility Comments:					
12A.3.1.2	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved. Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.					
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.				
		2. Minutes of meeting with evidence of cross reference with other departments				
		3. Documented cross departmental policies				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
12A.3.1.3	Current policies and procedures are communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings				
		2. Circulation list and acknowledgement				
	Facility Comments:					
12A.3.1.4 CORE	There is evidence of compliance with policies and procedures.					
	EVIDENCE OF COMPLIANCE	1. Compliance with policies and procedures through:				
		a) interview of staff on practices;				
		b) verify with observation on practices;				
		c) results of audit on practices;				
		d) practices in line with established policies and procedures.				
	Facility Comments:					
12A.3.1.5	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.					
	EVIDENCE OF COMPLIANCE	1. Copies of relevant policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.				
	Facility Comments:					
12A.3.1.6 CORE	Documented policies of a planned systematic approach to the provision of ambulatory Endoscopy care. These include:					
	a) available criteria for selection and assessment of cases; b) policy on the use of sedation during procedures; c) documented admission policies including age or disease limitations and the restrictions concerning the scope of clinical services offered;					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	d) the booking and admission of patients comply with admission policies; e) essential information on the service is given to all patients that outlines: i) the patient's pre-admission responsibilities and preparation; ii) the functioning of the Ambulatory Endoscopy Services; iii) type of anaesthesia and postanaesthetic effects; iv) provision for after-hours contact and emergency care; v) patient's post-discharge responsibilities/home care instructions. f) the requirements for a preanaesthetic assessment to be performed by a medical practitioner; g) patient identification, with the nature of the procedures and site of the procedure verified by the surgeon and the consent documents checked; h) observations of the patient's pre-, intra- ,and post-procedure status and vital signs are monitored and recorded in the medical record; i) a dedicated anaesthetist is present or readily available until all patients who have undergone anaesthesia/sedation are discharged; j) the discharge procedure ensures the patient is given relevant documented postoperative instructions and there is a responsible person/family members accompanying the discharged patient. The address and phone number of the discharge person/family members are recorded in the medical record. EVIDENCE OF COMPLIANCE 1. Documented policies that address (a) to (j). Facility Comments:			
12A.3.1.7	All patients and their relatives shall be given essential information pertaining to the procedure which include: a) the patient's pre-admission responsibilities and preparation; b) the functioning of the Ambulatory Endoscopy Services; c) type of anaesthesia and post anaesthetic effects; d) provision for after-hours contact and emergency care; e) the patient's post-discharge responsibilities/instructions.			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Patients and relatives given adequate information on the procedure carried out as evidenced by :			
		a) patient information pamphlet;			
		b) relevant contact number for any emergency care;			
		c) written post-operative instructions;			
		d) written follow up instruction.			
	Facility Comments:				
12A.3.1.8	The policies and procedures for management of emergency patients shall include arrangement for transfer of patients, where necessary.				
	EVIDENCE OF COMPLIANCE	1. Policies and procedures on management of emergency patients include:			
		a) patient transfer;			
		b) referral details including notes on patient's medical history.			
		2. Verification on compliance as per patient notes on transfer arrangement.			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 12A.4:		FACILITIES AND EQUIPMENT				
STANDARD 12A.4.1		<i>There are adequate physical facilities and equipment for safe and efficient functioning of the Ambulatory Endoscopy Services. The services may operate from a purpose-built facility with designated rooms for endoscopy.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
12A.4.1.1	There are adequate and appropriate facilities and equipment with proper utilisation of space to enable staff to carry out their professional, teaching and administrative functions.					
	EVIDENCE OF COMPLIANCE	1. Facilities for Ambulatory Endoscopy Services include the following:				
		a) adequate working space with suitable lighting;				
		b) storage space for equipment, surgical supplies, linen, housekeeping equipment, and pharmaceutical supplies, including the storage of dangerous and psychotropic drugs;				
		c) easy access;				
		d) facilities for disabled persons;				
		e) vehicle access to facilitate the safe admission and discharge of patients;				
		f) adequate provision for emergency power and uninterrupted power supply (UPS) where indicated.				
		g) adequate facilities and equipment at each patient care area for safe care. (e.g. defibrillators, emergency cart, hand washing facilities etc)				
	Facility Comments:					
12A.4.1.2	Equipment, both for emergency and non-emergency usage, shall be appropriate to the level of care.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Availability of emergency and non-emergency equipment appropriate to level of care, such as defibrillator, emergency trolley, suction machine, electrocardiogram (ECG) machine, infusion or syringe pump, vital signs monitor, etc				
		2. Proper cleaning / washing facilities for equipment				
		3. Proper sterilisation and storage facilities for endoscopes				
		4. Adequate medical gas and suction supplies				
		5. Fire extinguishers at relevant areas				
		6. Scheduled checking of items in emergency trolley				
	Facility Comments:					
12A.4.1.3	The Ambulatory Endoscopy Services shall comply with all safety features in accordance with regulatory requirements which include: a) electrical equipment complies with relevant electrical standards on the safe use of electricity in patient care; b) staff are aware of the appropriate procedures in the safe use and application of electromedical equipment; c) regular maintenance and monitoring of facilities and equipment, and a system to respond to breakdown repair and replacement; d) emergency biomedical equipment, e.g. defibrillator is checked at least once a day or after each use and the result is recorded; e) equipment complies with relevant standards, e.g. those set by Standards and Industrial Research Institute of Malaysia (SIRIM) and current statutory requirements.					
	EVIDENCE OF COMPLIANCE	1. Availability of Line Isolation and Overload Monitor (LIOM)				
		2. Certification or label of safety standards for equipment as required by law.				
		3. Awareness training of staff on use of and application of electromedical equipment.				
		4. Planned Preventive Maintenance (PPM), calibration and repair records				
		5. Defibrillator calibration testing record				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
12A.4.1.4	Where specialised equipment is provided by the attending medical practitioner, such equipment shall have the prior approval by the Person In Charge (PIC) of the Facility and should be checked to comply with the relevant safety requirements and be appropriately sterilised before use.				
	EVIDENCE OF COMPLIANCE	1. Policy on equipment provided by the attending medical practitioner including safety and sterilisation requirements.			
		2. Letter of approval by PIC on use of equipment provided by attending practitioner.			
		3. Planned Preventive Maintenance (PPM), calibration and repair records.			
	Facility Comments:				
12A.4.1.5	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.				
	EVIDENCE OF COMPLIANCE	1. Testing, commissioning and calibration records (certificates or stickers)			
		2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as evidence of compliance to the relevant standards and Acts.			
	Facility Comments:				
12A.4.1.6 CORE	There is evidence that the facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.				
	EVIDENCE OF COMPLIANCE	1. Planned Preventive Maintenance records such as schedule, stickers, etc.			
		2. Planned Replacement Programme where applicable			
		3. Complaint records			
		4. Asset inventory			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
12A.4.1.7	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.					
	EVIDENCE OF COMPLIANCE	1. User training records				
		2. Competency assessment record				
		3. Letter of authorisation				
		4. List of staff trained and competent to operate specialised equipment				
	Facility Comments:					
12A.4.1.8	Processing of the Endoscopy equipment a) Staff trained in processing of Endoscopy equipment b) Endoscopic cleaning / reprocessing room					
	EVIDENCE OF COMPLIANCE	1. Trained, knowledgeable staff of ambulatory Endoscopy				
		a) Training module				
		b) Logbook & certificate from Head of ambulatory Endoscopy services				
		2. Ideally the cleaning area should be accessible to the endoscopy rooms and designed in such a way to include both clean area (scope storage) as well as dirty area (scope reprocessing area).				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT																		
TOPIC 12A.5:		<u>SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES</u>																
<u>STANDARD 12A.5.1</u>		<i>The Head of Ambulatory Endoscopy Services shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Ambulatory Endoscopy Services. The Head of Ambulatory Endoscopy Services shall ensure compliance to monitoring of specific performance indicators.</i>																
		CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS														
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING													
12A.5.1.1		There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Ambulatory Endoscopy Services. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated. <table><tr><td rowspan="6">EVIDENCE OF COMPLIANCE</td><td>1. Planned performance improvement activities include (a) to (f)</td><td></td></tr><tr><td>2. Records on performance improvement activities</td><td></td></tr><tr><td>3. Minutes of performance improvement meetings</td><td></td></tr><tr><td>4. Performance improvement studies</td><td></td></tr><tr><td>5. Mortality and morbidity audits with remedial actions</td><td></td></tr><tr><td>6. Records on innovation if available.</td><td></td></tr></table> Facility Comments:	EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to (f)		2. Records on performance improvement activities		3. Minutes of performance improvement meetings		4. Performance improvement studies		5. Mortality and morbidity audits with remedial actions		6. Records on innovation if available.				
EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to (f)																	
	2. Records on performance improvement activities																	
	3. Minutes of performance improvement meetings																	
	4. Performance improvement studies																	
	5. Mortality and morbidity audits with remedial actions																	
	6. Records on innovation if available.																	
12A.5.1.2		The Head of Ambulatory Endoscopy Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement activities to appropriate individual/personnel within the respective services.																

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes of meetings				
		2. Letter of assignment of responsibilities				
		3. Job description				
	Facility Comments:					
12A.5.1.3	The Head of the Ambulatory Endoscopy Services shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility. Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.					
	EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:				
		a) Training of staff				
		b) Policy on incident reporting				
		c) Methodology of incident reporting				
		d) Register/records of incidents				
		2. Completed incident reports				
		3. Root Cause Analysis				
		4. Corrective and preventive action plans				
		5. Remedial measure				
		6. Minutes of meetings				
		7. Acknowledgment by Head of Endoscopy Service and PIC/Hospital Director				
		8. Feedback given to staff regarding incident reporting.				
	Facility Comments:					
12A.5.1.4 CORE	There is tracking and trending of specific performance indicators not limited to but at least two (2) of the following: a) cancellation rate of ambulatory Endoscopy cases b) No Show percentage of ambulatory Endoscopy cases					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored.				
		2. Records on tracking and trending analysis.				
		3. Remedial measures taken where appropriate.				
	Facility Comments:					
12A.5.1.5	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.					
	EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff.				
		2. Evidence of feedback via communication on results of performance improvement activities through continuing medical education/meetings.				
		3. Minutes of service/unit/committee meetings				
	Facility Comments:					
12A.5.1.6	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.					
	EVIDENCE OF COMPLIANCE	1. Documentation on performance improvement activities and performance indicators.				
		2. Policy statement on anonymity on patients and providers involved in performance improvement activities.				
	Facility Comments:					

SERVICE SUMMARY	
SURVEYOR SUMMARY:	
OVERALL RATING:	
OVERALL RISK:	

SURVEY ITEM & SELF-ASSESSMENT				
SERVICE STANDARD 12B : AMBULATORY CARE SERVICES (OPHTHALMOLOGY SERVICES)				
	<u>PREAMBLE</u> <i>Ambulatory care is defined as scheduled procedures provided to patients who do not require hospital stay overnight. It is a process of care where suitable patients are managed with admission, treatment and discharge on the same day. Ambulatory care is done for diagnostic and therapeutic procedures which may require topical, local, regional, monitored anaesthetic care or general anaesthesia, with minimal or do not carry risk of post-operative complications but require a period of observation in the Ambulatory Care Centre. Ambulatory care services can be provided as hospital based or stand-alone centres.</i> <i>There are guidelines to specify which patients can be treated, which procedures and under what form of anaesthesia/sedation can be performed as ambulatory care. The service could also include patients treated and managed in the day care for ophthalmological conditions, diagnostic and interventional procedures.</i> <i>Ambulatory care centre performing any procedure for the stay of any one patient for a period of not more than 23 hours is provided and from which patients are either discharged in an ambulatory condition without requiring constant or continuous care or supervision and without danger to the continued well-being of the patient or transferred to a hospital. [Reference: Private Healthcare Facilities and Services Act 1998 (Act 586)]</i>			
<u>TOPIC 12B.1:</u> <u>STANDARD 12B.1.1</u>	<u>ORGANISATION AND MANAGEMENT</u> <i>The Ophthalmology Ambulatory Care Services are organised to provide safe and efficient care for ambulatory patients. The service includes patients treated and managed in the day care for ophthalmological conditions, diagnostic and interventional procedures.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
12B.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Ophthalmology Ambulatory Care Services are clearly documented and measurable that indicates safety, quality and patient centred			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	care. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.				
		2. Goals and objectives of the Ophthalmology Ambulatory Care Services in line with the Facility/Centre's statements are available, endorsed and dated.				
		3. Evidence of planned reviews of the above statements.				
		4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)				
		5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.				
	Facility Comments:					
12B.1.1.2 CORE	There is an organisation chart which: a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head of the Ambulatory Care Services, consultants, medical practitioners and staff of the Ambulatory Care Services; b) to all staff and clients; c) includes off-site services if applicable; d) is revised when there is a major change in any one of the following: i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head of the Ambulatory Care Services, consultants, medical practitioners and staff of the Ambulatory Care Services.				
		2. Organisation chart of the service is endorsed, dated and accessible.				
		3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).				
	Facility Comments:					
12B.1.1.3	The Governing Body shall ensure that Ambulatory Care Services are organised in such a way as to: a) facilitate the provision of ambulatory care services to patients in the Facility in a safe, efficient, effective, and caring manner and with due regard for the needs, dignity and privacy of patients and confidentiality of their personal information; b) assure continuity of care; c) address the professional needs of the medical practitioners; d) ensure that the medical practitioners are involved in the formulation of policies and procedures concerning patient care appropriate to the scope of services of the Facility.					
EVIDENCE OF COMPLIANCE	1. Departmental/Centre-operational policies that address (a) to (d).					
	2. Medical Staff By-Laws					
	3. Evidence of involvement of medical practitioners in the formulation of policies and procedures concerning patient					
	4. Involvement of Head of the Service in the Medical Advisory Committee and service meetings.					
	5. Minutes of meetings					
Facility Comments:						

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
12B.1.1.4	The Ambulatory Care Services shall adopt a governing framework in accordance with statutory and other legal requirements.					
	EVIDENCE OF COMPLIANCE	1. License to operate (Private Healthcare Facility)/Gazettement letters and supporting documents (Public Healthcare Facility)				
		2. Appointment of full time Person In Charge (PIC) in accordance with the Fourth Schedule in Private Healthcare Facilities and Services Act 1998 and Regulations 2006.				
	Facility Comments:					
12B.1.1.5 CORE	The Person In Charge (PIC) of the Ambulatory Care Services (Ophthalmology Services)/Centre has : a) representation of the Service in relevant committees; b) heads clinical staff meetings; c) provides regular input on the operations of the Services to the Management Team.					
	EVIDENCE OF COMPLIANCE	1. Letter of appointment and delineation of duties and responsibilities of the Head of the Service/ Centre				
		2. Letter of appointment and Terms of Reference as member of the Medical Advisory Committee i.e. hospital based service				
		3. Minutes of meetings of Medical Advisory Committee/Management				
		4. Letter of appointment for representation in relevant committees, e.g., Operating Theatre Committee and minutes of meetings.				
Facility Comments:						
12B.1.1.6	Regular staff meetings are held between the Head of Service/Centre and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Ambulatory Care Services. Minutes are kept; decisions and resolutions made during					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	meetings shall be accessible, communicated to all staff of the service and implemented.				
	EVIDENCE OF COMPLIANCE	1. Minutes are accessible, disseminated and acknowledged by the staff.			
		2. Attendance list of members with adequate representatives of the service.			
		3. Frequency of meetings as scheduled.			
		4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).			
	Facility Comments:				
12B.1.1.7	The Head of the Ambulatory Care Services/Centre is involved in the planning, justification and management of the budget and resource utilisation of the services.				
	EVIDENCE OF COMPLIANCE	1. Minutes of Facility-wide management meeting			
		2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service.			
		3. Approved budget and resources.			
	Facility Comments:				
12B.1.1.8	The Head of the Ambulatory Care Services/Centre is involved in the appointment and/OR assignment of staff.				
	EVIDENCE OF COMPLIANCE	1. Records on staff interview (if applicable)			
		2. Appointment/assignment letter of Head of Service			
		3. Job description of Head of Service/Centre			
		4. Records on staff deployment			
		5. Duty roster			
	Facility Comments:				
12B.1.1.9	Ambulatory Care Services are provided appropriate to the Facility's scope of medical and surgical services.				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. List of ambulatory care services provided			
		2. Patient registration records			
	Facility Comments:				
12B.1.1.10	Appropriate statistics and records shall be maintained in relation to the provision of Ambulatory Care Services and used for managing the services and patient care purposes.				
	EVIDENCE OF COMPLIANCE	1. Records are available but not limited to the following:			
		a) workload/census;			
		b) annual report;			
		c) accident/incident reports;			
		d) staffing number and staff profile;			
		e) staff training records;			
		f) data on performance improvement activities, including performance indicators.			
	Facility Comments:				
12B.1.1.11	Appropriate records are maintained by the Ambulatory Care Services/Centre which are adequate for clinical, medicolegal, and evaluation purposes and include the following:				
	a) a record of medical practitioners conferred the privileges of performing specific procedures is available and accessible to all staff				
	b) a register of operations/procedures performed within the Ambulatory Care Services/Centre is maintained;				
	c) a record of the procedure performed is filed in the patient's medical record;				
	d) standard drug administration records are maintained and regulations relating to the control of drugs are followed;				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	e) documented evidence of the counting of accountable items used in the procedures (including operating theatre) and a copy of this is included in the patient's medical record.				
	EVIDENCE OF COMPLIANCE	1. Records maintained by Ambulatory Care Services include (a) to (e)			
		2. Privileges of clinical staff performing specific procedures is available at point of care.			
		3. Record of the procedure performed and documented in the patient's medical record details the following:			
		a) procedure performed;			
		b) date and time;			
		c) type of anaesthesia;			
		d) personnel involved in the procedure;			
		e) findings;			
		f) record of accountable items used in operating theatre;			
		g) the dressings applied and drainage systems inserted (where applicable);			
		h) postoperative orders;			
		i) discharge and follow up notes.			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT				
STANDARD 12B.1.2	<i>Where external services are used to assist in the operations of the Facility, these contracted or referral services shall meet the MSQH Standards of Accreditation.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
12B.1.2.1	There are written agreements on the appointment and provision of external services to the Facility, which include the following: a) The services shall meet all patient and environmental safety standards contained in the MSQH Standards of Accreditation, regardless of where the activities occur, on-site and off-site. b) There is documentation on the external aspects of the services which refer to: i) specification of formal lines of communication and responsibility between the external source provider and the Facility; ii) provision of services by personnel appropriately qualified to perform their duties; iii) adequate pick-up and delivery arrangements; iv) appropriate participation of the external service provider in committees of the Facility where applicable; v) arrangements for after-hours and emergency services; vi) quality control of the external services including involvement in safety and performance improvement activities of the Facility, as appropriate; vii) procedures for identifying and rectifying problems in the delivery of the services; viii) adequacy of facilities and equipment for the services being provided at both the Facility and the site of the external services; ix) personnel provided by the external services who shall be bound by the rules and regulations applicable to the staff of the Facility.			
EVIDENCE OF COMPLIANCE	1. Service contracts have appropriate terms and conditions as in (a) and (b) including:			
	a) date and duration of contract;			
	b) system for quality control of outsourced services (visit to off-site services, recognised certification, etc);			
	c) procedures for managing shortfall in service;			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		d) Involvement in performance measurement of the relevant services provided to the Facility.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT														
<u>TOPIC 12B.2</u>	<u>HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT</u>													
<u>STANDARD</u> <u>12B.2.1</u>	<i>The Ophthalmology Ambulatory Care Services shall be directed by a qualified and competent National Specialist Register (NSR) registered ophthalmologist and staffed by suitably qualified and competent clinical staff to achieve the goals and objectives of the services. Staff of the services have access to appropriate education programmes to maintain and improve their knowledge and skills.</i>													
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS											
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING										
12B.2.1.1	The Head and staff of the Ophthalmology Ambulatory Care Services/Centre shall be individuals qualified by education, training, experience and certification to commensurate the requirements of the various positions. The appointment of Head and staff of the Ophthalmology Ambulatory Care Services/Centre shall conform to the statutory requirements. <table><tr><td rowspan="3">EVIDENCE OF COMPLIANCE</td><td>1. Records on credentials of Head of Service and staff required to fill up the posts within the service (to match the complexity of the Facility and services) and certification/registration.</td><td></td></tr><tr><td>2. Appointment/assignment letter</td><td></td></tr><tr><td>3. Training and competency records</td><td></td></tr><tr><td colspan="3">Facility Comments:</td></tr></table>	EVIDENCE OF COMPLIANCE	1. Records on credentials of Head of Service and staff required to fill up the posts within the service (to match the complexity of the Facility and services) and certification/registration.		2. Appointment/assignment letter		3. Training and competency records		Facility Comments:					
EVIDENCE OF COMPLIANCE	1. Records on credentials of Head of Service and staff required to fill up the posts within the service (to match the complexity of the Facility and services) and certification/registration.													
	2. Appointment/assignment letter													
	3. Training and competency records													
Facility Comments:														
12B.2.1.2	There is documented evidence of appropriate training and competency for the granting of clinical privileging. The criteria for determining privileges are specified and documented. There is a structured process to ensure the stated criteria are uniformly applied to all applicants. These include: a) the criteria are designed to assure that patients will receive safe and quality care; b) the criteria for individual procedures are documented in detail; e.g. competency records/log books, application from the individual practitioner, recommendations from peer/referee and minutes of meeting; c) competency for each performance is dated, verified and signed by the supervisors;													

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	d) the period of time (two years and when as needed) for which the privileges are to be granted is specified; e) current registration with the local professional registration bodies, e.g. Malaysian Medical Council, National Specialist Register (NSR), Nursing Board, Medical Assistant Board, Malaysian Optical Council, Pharmacy Board; f) peer recommendations are taken into account when privileges are being considered; g) the recommendations of the relevant department and/or major professional services for privileges to be granted are taken into consideration.					
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures are established to govern the credentialing and privileging processes which include items (a) to (g).				
		2. Compliance with policy and criteria for credentialing and privileging				
		3. Annual Practising Certificate (APC), National Specialist Register (NSR) certificates and privileging certificates.				
		4. Recommendations from peer/referee				
		5. Availability of the list of procedures requiring credentialing and privileging.				
		6. Availability of list of procedures to include core procedures specific to the disciplines performed by medical officers; competency records/log books.				
	Facility Comments:					
12B.2.1.3	The authority, responsibilities and accountabilities of the Head of Ophthalmology Ambulatory Care Services/Centre are clearly delineated and documented.					
	EVIDENCE OF COMPLIANCE	1. Appointment/assignment letter for Head of Service.				
		2. Description of duties and responsibilities				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
12B.2.1.4	Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the need of the services and commensurate with the number of ophthalmologists and patients.			
	There shall be minimum one (1) nurse to four (4) patients at all times in pre-operative and recovery bay.			
	There shall be minimum two (2) registered nurses in one (1) operating room, including at least one (1) post basic ophthalmology trained nurse in each operating room. The number of nurses shall be commensurate with the number of operating rooms.			
	EVIDENCE OF COMPLIANCE			
	1. Number of staff and qualification should commensurate with workload.			
	2. Staffing pattern			
12B.2.1.5	3. Duty roster			
	4. Census and statistics			
	Facility Comments:			
	There are written and dated specific job descriptions for all categories of staff that include:			
	a) qualifications, training, experience and certification required for the position;			
	b) lines of authority;			
	c) accountability, functions and responsibilities;			
	d) reviewed when required and when there is a major change in one of the following:			
	i) nature and scope of work;			
	ii) duties and responsibilities;			
	iii) general and specific accountabilities;			
	iv) qualifications required and privileges granted;			
	v) staffing patterns;			
	vi) Statutory Regulations.			
	e) administrative and clinical functions.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	EVIDENCE OF COMPLIANCE	1.	Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e).				
		2.	Job description includes specialisation skills				
		3.	Relevant privileges granted where applicable				
		4.	The job description is acknowledged by the staff and signed by the Head of Service and dated.				
	Facility Comments:						
12B.2.1.6 CORE	Clinical staff performs within the privileges conferred						
	EVIDENCE OF COMPLIANCE	1.	Verification of procedures e.g. phacoemulsification, etc performed by individual at point of care within the awarded privileging rights with evidence of:				
		a)	list of procedures privileged;				
		b)	clinical notes.				
	Facility Comments:						
12B.2.1.7	Personnel records on training, staff development, leave and others are maintained for every staff. Note: Staff personal record may be kept in Human Resource Department as per Facility policy.						
	EVIDENCE OF COMPLIANCE	1.	Staff personal records include:				
		a)	staff biodata;				
		b)	qualification and experience;				
		c)	evidence of current registration;				
		d)	training record;				
		e)	competency record and privileging;				
		f)	leave record;				
		g)	confidentiality agreement.				
	Facility Comments:						

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS				
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING			
12B.2.1.8	There is a structured orientation programme for all newly appointed staff to the Ophthalmology Ambulatory Care Services/Centre including medical practitioners and for those new to specific areas that include the following: a) explanation of the goals, objectives, policies and procedures of the Facility and those of the Ophthalmology Ambulatory Care Service/Centre; b) lines of authority and areas of responsibility; c) explanation of particular duties and functions; d) explanation of the methods of assigning clinical care and the standards of clinical practice; e) handover communication; f) processes for resolving practice dilemmas; g) information about safety procedures; h) training in basic/advanced life support techniques; i) methods of obtaining appropriate resource materials; j) staff appraisal procedures for the Ophthalmology Ambulatory Care Services/Centre; k) education on WHO and Malaysian Patient Safety Goals (where applicable); l) education on Patient and Family Rights; m) education on MSQH Standards requirements.							
	EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme.						
		2. There is Ophthalmology Ambulatory Care Services/Centre orientation programme with relevant topics not limited to topics covered from (a) to (m).						
		3. Attendance list						
	Facility Comments:							
12B.2.1.9	There are continuing education activities for staff including medical practitioners to pursue professional interests and to prepare for current and future changes in practice.							
	EVIDENCE OF COMPLIANCE	1. Training calendar includes in-house/external courses/workshop/conferences						
		2. Contents of training programme						
		3. Training records on continuing education activities are kept and maintained for each staff including training in life support.						

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	4. Certificate of attendance/degree/post basic training					
	Facility Comments:					
12B.2.1.10	There is evidence of training needs assessment (example based on incidents and accidents that had occurred, complaints, patients' feedback, etc) and staff development plan which provides the knowledge and skills required for staff to maintain competency in their current positions and future advancement.					
	EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and gaps identified.				
		2. A staff development plan based on training needs assessment is available.				
		3. Training schedule/calendar is in place.				
		4. Training module				
	Facility Comments:					
12B.2.1.11	There are continuing education activities for staff including medical practitioners to pursue professional interests and to prepare for current and future changes in practice.					
	EVIDENCE OF COMPLIANCE	1. Training calendar includes in-house/external courses/workshop/conferences				
		2. Contents of training programme				
		3. Training records on continuing education activities are kept and maintained for each staff including training in life support.				
		4. Certificate of attendance/degree/post basic training				
	Facility Comments:					
12B.2.1.12	Medical practitioners (including consultants, specialists and medical officer) and staff receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for medical practitioners (including consultants, specialists and medical officer) and staff is completed upon probationary period and as an annual exercise.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 12B.3:		<u>POLICIES AND PROCEDURES</u>				
STANDARD <u>12B.3.1</u>		<i>Documented policies and procedures shall reflect the complexity of the services and commensurate with the current knowledge and evidence based practice for the ophthalmology ambulatory care services, and they are consistent with statutory requirements and the goals and objectives of the Ophthalmology Ambulatory Care Services/Centre.</i>				
		CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
12B.3.1.1 CORE	There are written policies and procedures for the Ophthalmology Ambulatory Care Services which are consistent with the overall policies of the Facility, regulatory requirements, current standard practices and clinical practice guidelines. These policies and procedures are signed, authorised and dated. There is a mechanism for and evidence of a periodic review at least once in every three years.					
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for the service.				
		2. Policies and procedures are consistent with the regulatory requirements and current standard practices.				
		3. Evidence of periodic review of policies and procedures.				
		4. The policies and procedures are endorsed and dated.				
	Facility Comments:					
12B.3.1.2	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved.					
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.				
		2. Minutes of meeting with evidence of cross reference with other departments/Centre				
		3. Documented cross departmental/centre policies				
	Facility Comments:					
12B.3.1.3	Current policies and procedures are communicated to all staff.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings				
		2. Circulation list and acknowledgement				
	Facility Comments:					
12B.3.1.4 CORE	There is evidence of compliance with policies and procedures.					
	EVIDENCE OF COMPLIANCE	1. Compliance with policies and procedures through:				
		a) interview of staff on practices;				
		b) verify with observation on practices;				
		c) results of audit on practices;				
		d) practices in line with established policies and procedures.				
	Facility Comments:					
12B.3.1.5	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.					
	EVIDENCE OF COMPLIANCE	1. Copies of relevant policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
12B.3.1.6 CORE	There are documented policies of a planned systematic approach to the provision of ambulatory patient care. These include:			
	a) criteria for selection and assessment of cases (refer to Day Care Surgery Standards Operating Procedure and Protocol for Day Care Anaesthesia, Ministry of Health); b) policy on the use of sedation during procedures; c) documented admission policies including age or disease limitations and the restrictions concerning the scope of clinical services offered; d) the booking and admission of patients comply with admission policies; e) essential information on the service is given to all patients;; f) the requirements for a pre-anaesthetic assessment to be performed by a medical practitioner (ophthalmologist, anaesthetist, medical officer trained in anaesthesiology/ophthalmology); g) patient identification, with the nature and site of the procedure marked and verified by the surgeon and the consent documents checked; h) observations of the patient's pre-, intra- ,and post-procedure status and vital signs are monitored and recorded in the medical record; i) pain management; j) a dedicated anaesthetist is present or readily available until all patients who have undergone general anaesthesia/deep sedation are discharged; k) the discharge procedure ensures the patient is given relevant documented postoperative instructions. l) there is a responsible person/family members accompanying the discharged patient undergone the procedures under general anaesthesia. The address and phone number of the discharge person/family members are recorded in the medical record			
	EVIDENCE OF COMPLIANCE 1. Documented policies that address (a) to (l).			
	Facility Comments:			

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
12B.3.1.7	A registered medical practitioner (RMP) shall be trained to carry out procedural sedation. When performed by non-anaesthesiologists, the level of sedation should be kept at minimal to moderate. Deep sedation should ONLY be done in the presence of an anaesthesiologist throughout the procedure.					
	EVIDENCE OF COMPLIANCE	1. Credential and privileging of registered medical practitioner carry out procedural sedation.				
		2. Policy on management of deep sedation.				
		3. Anaesthesiologist is present throughout the deep sedation procedure as observed during survey on site.				
	Facility Comments:					
12B.3.1.8	All patients and their relatives shall be given essential information pertaining to the procedure which include: a) the patient's pre-admission responsibilities and preparation; b) the functioning of the Ophthalmology Ambulatory Care Services; c) type of anaesthesia and post anaesthetic effects; d) provision for after-hours contact and emergency care; e) the patient's post-discharge responsibilities/instructions; f) follow-up instruction.					
	EVIDENCE OF COMPLIANCE	1. Patient information pamphlet				
		2. Relevant contact number for any emergency care				
		3. Patients and relatives given adequate information on the procedure carried out as evidenced as in medical records:				
		a) pre and post-operative checklist;				
		b) written post-operative instructions;				
		c) written follow up instruction				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
12B.3.1.9	The policies and procedures for management of emergency patients shall include arrangement for transfer of patients, where necessary.				
	EVIDENCE OF COMPLIANCE	1. Policies and procedures on management of emergency patients include:			
		b) patient transfer;			
		c) referral details including notes on patient's medical history.			
		2. Verification on compliance as per patient notes on transfer arrangement.			
		3. Policy on Code Blue			
	Facility Comments:				
12B.3.1.10	The Ophthalmology Ambulatory Care Services/Centre shall have a written transfer agreement/Memorandum of Understanding (MOU) with any hospital (preferable nearest hospital) whereby all registered medical practitioners performing procedure or surgery in the Ambulatory Care Centre shall have admitting privileges at such hospital. When transferring a patient to a hospital on an emergency basis, the Facility shall submit to the receiving hospital at the time of transfer a copy of all the medical records related to the patient's condition including observations of the patient's signs and symptoms, preliminary diagnosis, treatment provided, results of any tests and a copy of the informed written consent.				
	EVIDENCE OF COMPLIANCE	1. Memorandum of Understanding (MoU) with nearby healthcare facility in management of emergency events/ written transfer agreement with hospital			
		2. Copy of referral letter is available.			
		3. Contents in the referral letter are appropriately written and includes acceptance of the patient by the referred facility, name of receiving person.			
	Facility Comments:				
12B.3.1.11	There are policies and procedures for the Theatre Sterilising Supply Unit (TSSU). The policies and procedures shall include the following:				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
CORE	a) receiving and decontamination processes (disassembling, washing, cleaning and disinfection); b) packaging process (inspection, functionality check and packing); c) sterilisation process; d) validation processes; e) sterile storage and distribution; f) traceability and product recall; g) services provided to other healthcare facilities; h) environmental control (storage condition, effective maintenance of sterility); i) shelf life of sterile items appropriate to utilisation (turnover time); j) safety practices in TSSU ; k) utilisation of “flash” autoclave in operating theatre and clinics.					
	EVIDENCE OF COMPLIANCE	1. Policies and procedures that address TSSU processes but not limited to items (a) to (k) are available.				
	Facility Comments:					
12B.3.1.12	There shall be no reprocessing of any single-use medical-surgical instruments, equipment or supplies.					
	EVIDENCE OF COMPLIANCE	1. Policy on ‘No reprocessing’ of any single-use medical-surgical instruments, equipment or supplies.				
		2. Compliance with ‘No reprocessing’ policy.				
	Facility Comments:					
12B.3.1.13	Records for all activities in the processing of sterile items shall be maintained for a period of time as defined by respective regulatory authorities or in their absence as per policy of the healthcare facility.					
	EVIDENCE OF COMPLIANCE	1. Daily production statistics to assess stock (e.g. medical-surgical instruments, equipment or supplies) levels for safe, continuous service, efficient stock and cost control.				
		2. All tests performed on equipment and results.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		3. Steriliser records, e.g. number of cycles				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT	
STANDARD 12B.3.2	<i>Patient & Family Rights</i> <i>The Ophthalmology Ambulatory Care Services is responsible for providing processes that support patient and family rights from the point of accessing care.</i>

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
12B.3.2.1	The Facility's Management, medical practitioners and other clinical and Allied Health staff work collaboratively to protect and promote Patient and Family Rights. There is documented Patient and Family Rights Policy as identified in relevant laws and regulations that include, but are not limited to: a) access to information on all services provided by the Facility/Centre; b) access to safe and medically appropriate treatment regardless of race, culture, sex, nationality, or source of payment; c) access to an interpreter if language barrier exists; d) considerate, respectful, privacy and confidential medical care; e) information of the identity of the medical practitioner and other care givers; f) reasonable information to patient and next of kin about investigations, diagnosis, treatment and prognosis, including after discharge care and continuity of care and the right to second opinion; g) participation in making informed decisions concerning care including the right to refuse proposed treatment, experimental care, participation in research projects and the right to leave the Facility/Centre against medical advice; h) appropriate counseling prior to being granted discharge from the Facility/Centre against medical advice; i) information of applicable and relevant the Facility/Centre's rules and policies; j) administration of pain management where appropriate; k) advice on the approximate cost of treatment prior to the provision of care; l) information regarding financial and other assistance that may be available; m) receipt and examination of an itemised statement of all charges; n) information of the responsibilities of patients and families; o) access to health promotion information to facilitate their treatment in the Facility/Centre;			

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	p) access to information on quality and performance improvement in the Facility/Centre; q) provision of relevant information on the procurement, donation process and transplantation process where necessary.			
	EVIDENCE OF COMPLIANCE 1. There is documented Patient and Family Rights Policy as identified in the relevant laws and regulations that address items (a) to (q).			
	2. Compliance with the Patient and Family Rights Policy as observed on site.			
	Facility Comments:			
12B.3.2.2	There is a process designed to identify and respect patient's personal values, beliefs and religion and where applicable those of the patient's family.			
	EVIDENCE OF COMPLIANCE 1. Patient's religion and beliefs are identified			
	2. Orientation checklist addresses the needs of the patient.			
	Facility Comments:			
12B.3.2.3	The Facility/Centre takes measures to protect patient's possessions from theft or loss. The Facility/Centre has a policy that indicates its responsibility for patient's possessions and a system to ensure this policy is complied with.			
	EVIDENCE OF COMPLIANCE 1. Policy on patients possessions and records			
	2. On-site observation on compliance with the above policy.			
	Facility Comments:			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
12B.3.2.4	The Facility/Centre has a policy on risk identification and implementation of safety measures to protect patients from injury.					
	EVIDENCE OF COMPLIANCE	1. Policy on risk identification				
		2. Risk identification strategies, e.g. security guard, closed-circuit television (CCTV), fall prevention.				
	Facility Comments:					
12B.3.2.5	The Facility/Centre ensures patient health information as confidential.					
	EVIDENCE OF COMPLIANCE	1. Policy on safeguarding of patient information				
		2. Policy on release of patient's medical record.				
		3. Code of conduct of medical records staff				
		4. The following systems as observed on site:				
		a) Secured health information system with restricted access levels				
		b) Restricted access to Medical Records Unit				
		c) System for recording and monitoring movement of medical records.				
	Facility Comments:					
12B.3.2.6	Patients are informed of their rights to voice their complaints and the grievance mechanism.					
	EVIDENCE OF COMPLIANCE	1. Policy on grievance mechanism				
		2. Patient orientation checklist				
		3. Patient Charter				
		4. Brochure on Patient and Family Rights				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT	
STANDARD 12B.3.3	<u>Health Information Management System</u> <i>The Ophthalmology Ambulatory Care Services shall have an appropriate patient's medical record system comprising of facilities, procedures and organisation for keeping patient's medical records. The Health Information Management System (HIMS) shall be organised to ensure confidentiality*, safe keeping and easy retrieval of medical records and documents both paper based and electronic related to patient care.</i> <i>An accurate patient's medical record is maintained to facilitate optimal patient care and allow for evaluation of the care provided.</i> <i>*Personal Data Protection Act , PDPA 2013</i>

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
12B.3.3.1	A single record for every patient is maintained with integrated recording system by healthcare providers.				
	A single record is a record that is a composite of all data on a given patient. Their entire medical record is in one folder under one medical record reference number.				
	Integrated record is a system of joint recording by various healthcare providers who record information around the patient (patient based) according to sequence of events.				
	EVIDENCE OF COMPLIANCE	1. A single record system is implemented.			
		2. Integrated records are practiced.			
Facility Comments:					
12B.3.3.2	There is a system for patient identification, cross referencing and a filing system that allows rapid retrieval of records.				

	EVIDENCE OF COMPLIANCE	1. Policies and procedures for patient identification, cross referencing and a filing system that allows rapid retrieval of records.				
	Facility Comments:					
12B.3.3.3	There is a policy for safeguarding the information in the record against breach of confidentiality, loss, damage, or use by unauthorised personnel.					
	There are policies and procedures on information storage and recovery including procedures for data recovery in case of malfunctions or disaster.					
	EVIDENCE OF COMPLIANCE	1. Policy for safeguarding the information in the record against breach of confidentiality, loss, damage, or use by unauthorised personnel is in place.				
		2. Guidelines for management of medical records, electronic information system security and user access control policies (paper based and electronic information systems).				
		3. Mechanisms are in place to support Facility/Centre -wide and HIMS functions even in case of unexpected failure or				
12B.3.3.4	Facility Comments:					
	Informed consent is obtained before surgery, anaesthesia, and other high risk treatment and procedures, and the information given shall be documented in the medical records.					
	The informed consent shall be obtained by the medical practitioner performing the procedure.					
	EVIDENCE OF COMPLIANCE	1. Signed consent forms. (The procedure is only performed after the consent taken.)				
		2. Evidence of documentation in medical records (explanation given at the time of taking consent)				
	Facility Comments:					

12B.3.3.5	The medical practitioner records the preoperative diagnosis and there is an operative report immediately after surgery, including: a) date, time and duration; b) description of the findings; c) the procedure performed; d) tissue removed; e) tissue sent for pathological examination; f) preoperative and postoperative diagnosis; g) postoperative instructions; h) surgeon's name and signature including name of assistant where applicable.			
EVIDENCE OF COMPLIANCE	1. Sampling of medical records to verify operative report addressing items (a) to (h).			
	Facility Comments:			
12B.3.3.6	The patient's medical record contains information particularly relating to anaesthesia including: a) date, time and duration; b) informed consent of anaesthesia; c) evidence of a preoperative assessment by an anaesthetist, preferably by the attending anaesthetist; d) drugs and doses given during anaesthesia and route of administration; e) monitoring data; f) intravenous fluid therapy, if given; g) post anaesthetic instructions, where appropriate; h) name and signature of attending anaesthetist.			
EVIDENCE OF COMPLIANCE	1. Samplings of medical records and verify the notes containing anaesthetic report addressing items (a) to (h).			
	Facility Comments:			
12B.3.3.7	There is a policy on the retention of medical records and there are guidelines on the appropriate storage of active and inactive records. Records shall be preserved at least			

	for the period as specified under the written law pertaining to limitation period (e.g. Statute of Limitation, National Archives Policy).					
	EVIDENCE OF COMPLIANCE	1. Policy and guidelines on the retention of medical records.				
		2. Records on medical records disposal				
		3. On-site observation on storage of medical records				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT					
STANDARD 12B.3.4	PREVENTION AND CONTROL OF INFECTION <i>The Facility designs and implements a coordinated programme to reduce the risks of Facility acquired infections in patients and staff. Responsibility for infection control is undertaken by the Person In Charge.</i>				
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
12B.3.4.1	A designated staff who has training in prevention and control of infection shall oversee all prevention and control of infection measures in the Centre. The staff in-charge has delegated authority for the supervision and effective implementation of infection control policies, and is responsible for surveillance of healthcare associated infections on a systematic and current basis.				
	EVIDENCE OF COMPLIANCE	1. Designated nurse with training in prevention and control of infection oversee the prevention and control infection measures.			
		2. Surveillance reports and records			
		3. Environmental inspection records			
		4. On-site training records conducted by staff in-charge			
	Facility Comments:				
12B.3.4.2	There are safety measures taken to ensure the protection of the Facility's staff and environment against healthcare associated infections. Records shall be kept on action taken which include: a) staff education; b) staff health screening including infectious diseases; c) staff immunisation; d) staff health record maintenance; e) provision for adequate and good quality personal protective equipment (PPE); f) implementation of safety devices; g) clinical waste management; h) environmental infection risk;				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	i) protocol for post-exposure management for infectious disease and for assignment of infected staff.				
	EVIDENCE OF COMPLIANCE 1. Where appropriate, records are kept on actions taken which include items (a) to (i).				
	Facility Comments:				
12B.3.4.3	Provision is made for the personal comfort and safety of patients and staff which include: a) clean and hygienic facilities; b) room temperatures are kept at comfortable levels; c) disinfection and sterilisation areas; safe equipment and instruments; d) proper hand hygiene facilities; e) aseptic techniques for procedures; f) practice of standard and additional precautions.				
	EVIDENCE OF COMPLIANCE 1. There is evidence of items (a) to (f) being implemented.				
	Facility Comments:				
12B.3.4.4	There are written infection control policies and procedures relevant to the scope of services, complexity of the Facility and level of risks consistent with national and international requirements. There is evidence of compliance with policies and procedures and evidence based guidelines (World Health Organization/Centers for Disease Control and Prevention/Ministry of Health).				
	EVIDENCE OF COMPLIANCE 1. On-site observation for Infection control practices				
	2. Audit reports on infection control practices				
	3. Incident reports related to infection control				
	4. Staff health report on cases related to infection control				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	5. National and local antibiotic guidelines				
	Facility Comments:				
12B.3.4.5	All anaesthetic procedures shall comply with standard infection control guidelines to prevent cross infection between patients. Breathing apparatus shall not be shared and disposable items shall not be reused.				
	EVIDENCE OF COMPLIANCE	1. Guidelines on infection control policy in the operating theatre are available and adhered to.			
		2. Reusable anaesthetic items and equipment are sterilised according to infection control guidelines.			
		3. Single use anaesthetic items are disposed after each use.			
	Facility Comments:				
12B.3.4.6	The Person In Charge (PIC) and designated nurse in-charge of infection control shall take necessary measures to ensure that:				
	a) proposed demolition, building constructions and renovations are designed in line with accepted infection control requirements;				
	b) proposed new equipment intended for patient care conforms to accepted infection control standards.				
	EVIDENCE OF COMPLIANCE	1. Records on input PIC and nurse in-charge of infection control for (a) and (b) where applicable.			
	Facility Comments:				
12B.3.4.7	The Person In Charge (PIC) and designated nurse in-charge of infection control reviews reports on healthcare associated infections rates, surveillance studies of infections and infection potentials, and the implementation of infection control policies. Pertinent findings shall be submitted to the appropriate source for necessary action.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes of Infection Control Committee meeting				
		2. Reports on:-				
		a) healthcare associated infection rates;				
		b) surveillance data on infections and infection potentials;				
		c) implementation of infection control policies.				
		3. Records on pertinent findings submitted to the appropriate source for necessary action to be taken.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT	
STANDARD 12B.3.5	PHARMACY SERVICES <i>The Pharmacy Services shall be organised and administered to provide efficient pharmaceutical care services including the purchase, distribution, and control of pharmaceutical products; and to disseminate appropriate drug information to the healthcare team and patients of the Facility in accordance with prevailing standards of pharmacy practice.</i>

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
12B.3.5.1	There are policies and procedures on ordering and administering of medicines which include: a) incorporation of patient medication orders into the patient's medical record; b) recording in the patient's medical record for every dose of medicine administered; c) keeping accurate and accessible records on medicines supplied and administered to inpatients and outpatients; d) administering of medicines brought into the Facility/ Centre by patients; e) administering of medicines by patients, where appropriate; f) access to patients' medical records, where appropriate; g) abbreviations where used are in accordance with an approved list and this list is endorsed by the Person In Charge (PIC); h) reconstitution, storage, transportation and administration of cytotoxic drugs (where applicable).				
	EVIDENCE OF COMPLIANCE	1. Policies and procedures on ordering and administering of medicines include (a) to (i).			
		2. Prescription patterns			
		3. Medication administration			
		4. Patient medication record			
		5. Records on order, worksheet, preparation, supply and transportation of cytotoxic drug.			
		6. Drug reconciliation policy			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
12B.3.5.2	There are documented policies and procedures on prescribing medication that state:			
	a) medicines can only be dispensed by qualified pharmacy personnel based on written order from the medical practitioner;			
	b) electronic prescribing, using an open or closed network if practiced, conform to established conventions with regards to the identity of the prescriber and patient;			
	c) drugs dispensed and administered are based on the original of the medical practitioner's order. Drug orders are not transcribed.			
	EVIDENCE OF COMPLIANCE			
	1. Policies and procedures include (a) to (c) are available.			
12B.3.5.3	2. Security access is established for electronic prescribing.			
	3. Records on original prescription.			
	4. Updated sample of doctors' signature for manual prescribing.			
	Facility Comments:			
12B.3.5.3	There is adverse drug reaction reporting system in place. Policies and procedures for Adverse Drug Reaction (ADR) Reporting shall include the method of detection, a mechanism for reporting to the medical practitioner, the pharmacist, the Adverse Drug Reaction Advisory Committee/appropriate internal committee (where applicable).			
	EVIDENCE OF COMPLIANCE			
	1. Appropriate committee to discuss the ADR incidents.			
	2. Policies and procedures are in place for ADR reporting			
	3. Sample of ADR reports and dissemination of findings			
	Facility Comments:			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
12B.3.5.4	There is a system for reporting of medication errors, identifying the root cause and corrective action taken to prevent similar errors.					
	EVIDENCE OF COMPLIANCE	1. Standard operating procedures for reporting of medication error				
		2. Sample of medication error report				
		3. Evidence of corrective action taken and dissemination of findings.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 12B.4: FACILITIES AND EQUIPMENT						
STANDARD 12B.4.1		There are adequate physical facilities and equipment for safe and efficient functioning of the Ophthalmology Ambulatory Care Services. The services may operate from a purpose-built facility with designated rooms such as ophthalmology clinics (including facility providing diagnostic services), day care wards, operating theatre (with Anaesthetic Services and without Anaesthetic Services) and Central Sterilising Supply Services.				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
12B.4.1.1	There are adequate and appropriate facilities and equipment with proper utilisation of space to enable staff to carry out their professional, teaching and administrative functions.					
	EVIDENCE OF COMPLIANCE	1. Facilities for Ophthalmology Ambulatory Care Services include the following:				
		a) adequate working space with suitable lighting;				
		b) storage space for equipment, surgical supplies, linen, housekeeping equipment, and pharmaceutical supplies, including the storage of dangerous and psychotropic drugs;				
		c) easy access;				
		d) facilities for disabled persons;				
		e) vehicle access to facilitate the safe admission and discharge of patients;				
		f) adequate provision for emergency power and uninterrupted power supply (UPS) where indicated.				
		g) adequate facilities and equipment at each patient care area for safe care. (e.g. defibrillators, emergency cart, hand washing facilities etc)				
	Facility Comments:					
12B.4.1.2	Existing facilities shall take cognisance of the safety of staff and patients.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Design and layout of the Ophthalmology Ambulatory Care Services, e.g. wards, treatment rooms, dirty and clean utility rooms, access, lighting, signage, etc address the safety aspects of patients and staff.				
		2. At least a short-stay drop off and pick up point immediately adjacent to the unit and ward.				
		3. Adequate equipment and supplies for Ophthalmology Ambulatory Care Services, e.g. emergency trolley, functioning patient call bell, etc.				
		4. Equipment should have scheduled planned preventive maintenance (PPM).				
	Facility Comments:					
12B.4.1.3	Suitable and adequate forms of communication and intercommunication systems and equipment are provided to enable clinical staff to communicate among themselves and with the other members of the healthcare team.					
	EVIDENCE OF COMPLIANCE	1. Appropriate telecommunication modalities available for daily operation and during emergencies.				
	Facility Comments:					
12B.4.1.4	There is documented evidence that equipment and instruments complies with relevant national/international standards and current statutory requirements. All biomedical equipment shall comply with Medical Device Act 2012.					
	EVIDENCE OF COMPLIANCE	1. Testing, commissioning and calibration records (certificates or stickers)				
		2. Certification of equipment and instruments from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as evidence of compliance to the relevant standards and Acts.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		3. Medical device registration certificate from Medical Device Authority.				
	Facility Comments:					
12B.4.1.5 CORE	There is evidence that the facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.					
	EVIDENCE OF COMPLIANCE	1. Planned Preventive Maintenance records such as schedule, stickers, etc.				
		2. Planned Replacement Programme where applicable				
		3. Complaint records				
		4. Asset inventory				
	Facility Comments:					
12B.4.1.6	Emergency biomedical equipment is thoroughly tested as a routine, e.g. defibrillators are discharged and output checked every day or after each use, and the results recorded.					
	EVIDENCE OF COMPLIANCE	1. Records on regular inspection and checking biomedical equipment (electrocardiogram strips for defibrillator)				
		2. Policy and schedule on checking biomedical equipment				
	Facility Comments:					
12B.4.1.7	Where specialised equipment (e.g. optical radiation devices, etc) is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.					
	EVIDENCE OF COMPLIANCE	1. User training records				
		2. Competency assessment record				
		3. Letter of authorisation				
		4. List of staff trained and competent to operate specialised equipment				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	Facility Comments:				
12B.4.1.8	Equipment is upgraded (based on evidence) from time to time to keep pace with advancement in operative and diagnostic techniques and technology.				
	EVIDENCE OF COMPLIANCE	1. Equipment are being replaced and upgraded to meet current standard of care and advancement in technology in a planned and systematic manner.			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT					
STANDARD 12B.4.2		FACILITIES FOR OUTPATIENT SERVICES There are adequate outpatient clinics to enable the provision of safe and effective patient care; and patient privacy and confidentiality are assured.			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
12B.4.2.1	The Ophthalmology Outpatient Services shall have the following features: a) the organisation and management of the clinics are planned so as to ensure prompt attention to patients, minimal waiting time, and avoidance of unnecessary visits by the patients; b) record keeping shall be efficient; c) an appointment or queuing system is used to manage patient consultations; d) the clinic is easily accessible including for non-ambulant patients and is easily identified through adequate signage; e) adequate provision is made for patient comfort.				
	EVIDENCE OF COMPLIANCE	1. The Ophthalmology Outpatient Services address (a) to (f) with evidence of but not limited to the following:			
		a) list of services available and offered to patients;			
		b) flow chart on work process;			
		c) safe keeping of medical records;			
		d) security of data in Health Information System;			
		e) clinic appointment system;			
		f) monitoring of waiting time;			
		g) adequate and appropriate signage;			
		h) floor plan indicates accessibility to supporting services and optimisation of space;			
		i) adequate patient personal use items, e.g. wheelchair, etc.			
		j) adequate waiting area, rest rooms, refreshments, reading material and parking space.			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
12B.4.2.2	Adequate numbers of rooms are provided to ensure patient privacy and confidentiality for various patient care activities including: a) consultation (not more than one patient in a room at any time); b) conduct of minor procedures and nursing procedures; maintain a register of procedures performed; c) performance of various tests.					
	EVIDENCE OF COMPLIANCE	1. Adequate facilities for consultation and patient care activities that address (a) to (c) with evidence of but not limited to the following:				
		a) privacy of patient is ensured;				
		b) procedure room is appropriately equipped;				
		c) patient monitoring device is available where required;				
		d) list of procedures done.				
	Facility Comments:					
12B.4.2.3	When an optometrist is present, examination room shall be set up according to standards to enable precise measurement.					
	EVIDENCE OF COMPLIANCE	1. List of Standard and Alternative Facilities in the Optometry Standard Operating Procedures is to be used as reference in setting up of Optometry examination room.				
		2. Observation on-site during survey				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT	
TOPIC 12B.4:	<u>FACILITIES AND EQUIPMENT FOR DAY CARE WARD</u>
STANDARD 12B.4.3	<i>Adequate facilities and equipment shall be available to provide safe and effective patient care in the day care ward.</i>

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
12B.4.3.1	Facilities are suitably located to facilitate easy access and to provide an atmosphere of user, environmental and 'disabled' friendly.					
	EVIDENCE OF COMPLIANCE	1. Floor plan indicates accessibility and patient and user friendly.				
		2. Feedback from patient experience				
		3. Incident reporting relating to facilities if any				
	Facility Comments:					
12B.4.3.2	Equipment, both for emergency and non-emergency usage, shall be appropriate to the level of care.					
	EVIDENCE OF COMPLIANCE	1. Availability of emergency and non-emergency equipment appropriate to level of care, such as defibrillator, emergency trolley, suction machine, electrocardiogram (ECG) machine, infusion or syringe pump, vital signs monitor, functioning patient call bell, etc.				
		2. Proper cleaning / washing facilities for equipment				
		3. Proper disinfection, sterilisation and storage facilities for instruments.				
		4. Adequate medical gas and suction supplies				
		5. Fire extinguishers at relevant areas				
		6. Scheduled checking of items in emergency trolley				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
12B.4.3.3	The day care ward of Ophthalmology Ambulatory Care Services shall comply with all safety features in accordance with regulatory requirements which include: a) electrical equipment complies with relevant electrical standards on the safe use of electricity in patient care; b) staff are aware of the appropriate procedures in the safe use and application of electromedical equipment; c) regular maintenance and monitoring of facilities and equipment, and a system to respond to breakdown repair and replacement; d) emergency biomedical equipment, e.g. defibrillator is checked at least once a day or after each use and the result is recorded;					
	EVIDENCE OF COMPLIANCE	1. Certification or label of safety standards for equipment as required by law.				
		2. Awareness training of staff on use of and application of electromedical equipment.				
		3. Planned Preventive Maintenance (PPM), calibration and repair records				
		4. Defibrillator calibration testing record				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT				
STANDARD 12B.4.4	<u>Operating Theatre for Ophthalmology Ambulatory Care Services</u> <i>There are adequate and appropriate physical facilities and equipment for the safe and efficient functioning of the operating theatre (OT) facilities. Day care anaesthesia services shall be provided in an integrated set up using the dedicated operating theatres when applicable.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
12B.4.4.1	The design of the operating suite provides adequate space for the reception, anaesthesia induction, surgery, post-surgical recovery and observation of patients. This shall include not limited to: a) suitable areas for reception and for patients awaiting surgery; b) operating theatres; c) recovery area; d) adequate storage space for equipment, surgical supplies, linen, housekeeping equipment, and pharmaceutical supplies, including dangerous and psychotropic drugs; e) areas for administrative office, and where required, teaching facilities; f) areas for the collection and disposal of used equipment and waste; g) male and female staff change rooms; h) staff facilities, e.g. tea room, locker area; i) there is plan for providing improved staff facilities when the Facility undergoes refurbishment or redevelopment if any of the above are deemed inadequate.			
EVIDENCE OF COMPLIANCE	1. The design and layout of the operating suite provide adequate space and includes features as listed in (a) to (i).			
	2. Adequate recovery bay is available for post-operative cases.			
	Facility Comments:			

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
12B.4.4.2	The design of the operating theatre supports efficient systems for the management of perioperative services which include: a) operating rooms are treated as “clean” rooms with yearly performance test undertaken to ensure “clean” room status is maintained; b) ventilation system should provide positive pressure from the cleanest areas to less clean area; c) definitive traffic flow patterns and demarcation of sterile and non-sterile zones which enable enforcement of sterility discipline; d) ready access for routing emergency patients; e) fire detection, alarm, and suppression systems; firefighting equipment and appropriate sign posting; f) adequate means of egress from the operating suite in the event of fire; g) free movement of patient trolleys/wheelchairs throughout the suite with a minimum of cross traffic; h) reception of the patient in close proximity to the junction of sterile and non-sterile zones (air-lock zone); i) uninterrupted power supply (UPS) system in operating theatres shall be provided with an alarm system at the reception counter which will be triggered when the system is not charged; j) the medical gas system in the operating theatres shall be monitored to ensure that it is functioning; k) the quantity of medical gas terminal units be sufficient as required under national and international standards; l) colour coding for electrical outlets shall be according to international standards.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. The design and layout of the operating theatre provide adequate space and includes features as listed in (a) to (l)				
		2. Internal air quality report (IAQ),				
		3. Temperature (18°C-22°C) and humidity (50%-60%) are monitored.				
		4. Air change per hour (at least 20 air changes per hour)				
		5. Fire escape plan clearly posted.				
		6. Verification of the appropriateness of the design of the operating suite by on-site inspection.				
		7. Log book on medical gas monitoring				
	Facility Comments:					
12B.4.4.3	The requirements for other systems to support perioperative services include: a) adequate numbers of general power outlets distributed according to needs of each area; b) adequate provision for emergency power outlets for lighting and suction of an appropriate nature complying with current Malaysian Standards; c) suitable lighting; d) adequate medical gas and suction supplies complying with current Malaysian Standards; e) a means of environmental control of temperature and humidity within safe limits for anaesthetised patients undergoing surgery/procedures. Note: Environmental control shall ensure that air quality complies with relevant standards for various treatment or functional areas in respect of temperature, relative humidity and particle count.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Verification of other support systems in the operating suite includes items listed (a) to (e).				
		2. Evidence of minimum of two suction ports (one for anaesthesia and one for surgeon) per operating room. (If inadequate, then there must be portable suction devices for operating theatre needs)				
		3. Temperature maintained at 18°C - 22°C and relative humidity 50% - 60%.				
	Facility Comments:					
12B.4.4.4	The operating theatre shall comply with all safety features in accordance with regulatory requirements which include:					
	a) scavenging of anesthetic gases and vapors where general anaesthesia is provided;					
	b) regular maintenance and monitoring of facilities and equipment, and a system to respond immediately to breakdown, repair, and replacement;					
	c) electrical equipment which comply with Malaysian Standards;					
	d) appropriate personal protective equipment are provided in the presence of biohazards or laser procedures.					
	EVIDENCE OF COMPLIANCE	1. The operating theatre complies with all safety features in accordance to regulatory requirements as addressed in (a) to (d).				
		2. Verification of the above through on-site inspection.				
		3. Warning signs is placed outside the operating theatre if laser is in use.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
12B.4.4.5 CORE	The requirements for equipment used in the operating theatre shall include the following: a) a range of basic and specialised ophthalmology equipment in quantities sufficient to support the ophthalmology programme; b) where loan equipment is required, the loan equipment shall be delivered at least 48 hours to the Facility for appropriate decontamination/disinfection/sterilisation to be done before use; c) where general anaesthesia is provided, minimum standards for monitoring in anaesthesia as defined by the Malaysian Society of Anesthesiologists or the College of Anaesthesiologists of the Academy of Medicine of Malaysia (current edition); d) emergency and resuscitation equipment and supplies; with clearly defined instructions on how to operate the equipment and there is evidence that staff are trained to use the equipment.				
	EVIDENCE OF COMPLIANCE	1. The requirements for equipment used in the Operating Suite Services shall include items (a) to (d).			
		2. Verification of above through on-site inspection			
		3. Policy on handling and maintenance of loan equipment			
		4. Resuscitation drugs and equipment are in accordance to "Recommendations for Patient Safety and Minimal Monitoring Standards during Anaesthesia and Recovery" (Current Edition).			
		5. Presence of difficult intubation trolley, complete with airway devices and algorithm for CICV (can't intubate, can't ventilate) scenario where applicable.			
		6. Protocol for management of malignant hyperthermia (MH) and local anaesthetic toxicity, including statement on accessibility of drugs to treat these specific conditions are available where applicable.			
	Facility Comments:				
12B.4.4.6	Where general anaesthesia is provided, there shall be adequate space for patient recovery from anaesthesia with minimum 1 recovery bay to 1 operating room (current MOH Day Care Surgery SOP). The recovery room shall be appropriately staffed and				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	equipped for resuscitation and monitoring. The nurse to patient ratio shall be based on patient's conscious level i.e.1:1 for unconscious patient and 1:3 for conscious patients.							
	EVIDENCE OF COMPLIANCE	1. The patient recovery area is in the vicinity of the operating room and readily accessible to the anaesthetist.						
		2. Availability of resuscitation equipment in case of emergency.						
		3. Adequate number of nurses according to norms and suitably qualified and trained to assist in anaesthetic emergencies.						
	Facility Comments:							
12B.4.4.7	Anaesthetic delivery systems shall be kept in good condition with regular maintenance and there is a system to respond immediately to breakdown repair.							
	EVIDENCE OF COMPLIANCE	1. Documented evidence of maintenance records on all equipment used in the delivery of anaesthesia						
		2. System on respond to breakdown repair						
	Facility Comments:							
12B.4.4.8 CORE	All patients who are anaesthetised shall have adequate monitoring as specified by the document "Safety Standards for Anaesthesia and Recovery" published by the Malaysian Society of Anaesthesiologists. The monitoring shall include the minimum of monitoring of electrocardiogram (ECG), blood pressure, pulse, respiration, oxygen saturation, capnometry and others as may be necessary.							
	EVIDENCE OF COMPLIANCE	1. Compliance to standard guidelines on monitoring of anaesthetised patients, i.e. "Safety Standards for Anaesthesia and Recovery".						
	Facility Comments:							

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
12B.4.4.9	Anaesthetic delivery systems shall have safety features to prevent accidental hypoxia or disconnection of breathing circuits during mechanical ventilation. These will include anti-hypoxic devices, alarms for oxygen pressure failure, and ventilator disconnect alarms.					
	EVIDENCE OF COMPLIANCE	1. Availability of general anaesthesia (GA) machines with the required safety features.				
	Facility Comments:					
12B.4.4.10	Anaesthetic waste gases and vapours shall be scavenged.					
	EVIDENCE OF COMPLIANCE	1. Evidence of functional Anaesthetic Gas Scavenging Systems				
	Facility Comments:					
12B.4.4.11	An emergency alert shall be available within the operating suite area to call for assistance in the event of a serious adverse event in any operating room.					
	EVIDENCE OF COMPLIANCE	1. Availability of emergency alert				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT	
STANDARD 12B.4.5	Theatre Sterilising Supply Unit (TSSU) <i>The TSSU in the Ophthalmology Ambulatory Care Services/Centre is appropriately designed, installed and operated with adequate facilities and equipment to the needs of the services to assure that reprocessed medical devices and other sterilised products achieve high assurance levels of sterility.</i>

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
12B.4.5.1 CORE	The design and set up of the Theatre Sterilising Supply Unit allows for: a) The TSSU to be equipped and arranged to provide proper separation of clean and dirty routes and processes with clear demarcation of the different zones. The airflow is from clean to soiled areas. b) Areas within TSSU shall be adequate to provide for: i) <u>Receiving of unsterile supplies</u> - Facilities for receiving, disassembling and cleaning of supplies and equipment shall be appropriately located avoiding non-sterile items passing through sterile areas of the TSSU. ii) <u>Assembling and Packaging</u> - Facilities for assembling, packaging supplies and equipment shall have hand hygiene facilities, work counter (a non-porous material work benches) or its equivalent as required by types and volume of items. iii) <u>Sterilisation</u> - Facilities for sterilising shall be located between packaging area and sterile storage area. iv) Adequate storage areas for sterile instruments and supplies, unsterilised linen, unsterile instruments, equipment and surgical supplies and chemical detergents and disinfectants. c) Hand washing facilities d) Staff changing room are readily available.			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	e) Suitably planned layout of work benches and equipment.					
	EVIDENCE OF COMPLIANCE	1. The design and set up of the TSSU address all items (a) to (e) as per relevant regulations and as evidenced by:				
		a) demarcation with physical structure between the operating theatre and TSSU; there should be no crisscrossing of non-sterile and sterile items;				
		b) appropriate areas that facilitates the activities of sterilisation supply services;				
		c) compliance with Infection Control Policies and practices;				
		d) appropriate work benches at assembling and packaging area.				
	Facility Comments:					
12B.4.5.2	All sterilising systems (e.g. mechanical and chemical system) are maintained in accordance with statutory regulations.					
	EVIDENCE OF COMPLIANCE	1. Manual and log book of mechanical sterilising system				
		2. Planned preventive maintenance schedule and records				
	Facility Comments:					
12B.4.5.3 CORE	There are special automated equipment appropriate to the TSSU for the cleaning, drying, and sterilisation of surgical micro equipment, and they comply with acceptable standards.					
	EVIDENCE OF COMPLIANCE	1. Appropriate equipment to match complexity of the facility's services such as:				
		a) washer disinfectors;				
		b) ultrasonic washer;				
		c) dryer;				
		d) heat sealing equipment;				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		e) rapid biological test incubator.				
	Facility Comments:					
12B.4.5.4 CORE	Validation on sterilisation process using mechanical, chemical and biological tests are conducted and results monitored and recorded accordingly.					
	EVIDENCE OF COMPLIANCE	1. Performance of relevant tests and results:				
		a) mechanical test results records;				
		b) chemical test result records;				
		c) biological test result records				
		2. Records on deviations if any and corrective and preventive actions taken.				
		3. Relevant efficacy test records considering mechanical aspects, chemical aspects, temperature and time.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT				
STANDARD 12B.4.6	Linen Services <i>The Linen Services include the supply and delivery of clean linen and the collection and off site washing of dirty and soiled linen.</i> <i>For stand-alone Ophthalmology Ambulatory Care Services, the use of disposable surgical linen is advisable to ensure sterility. If reusable surgical linen is used, a monitoring system shall be in place which comply with Prevention and Control of Infection standards.</i> <i>There is adequate supply of clean linen/disposable surgical linen and protective clothing in the Ophthalmology Ambulatory Care Services. They are properly handled and stored in such a way as to avoid re-absorption of moisture and contamination from surface contact or airborne.</i>			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT
				SURVEYOR RATING
12B.4.6.1	The patient shall be in clean linen throughout the procedure.			
	EVIDENCE OF COMPLIANCE	1. Policy on linen supply		
		2. Patients have clean linen as evidenced on-site.		
	Facility Comments:			
12B.4.6.2	Soiled linen is collected in such a manner as to avoid microbial dissemination and it is placed in segregated bags or containers at the site of collection.			
	EVIDENCE OF COMPLIANCE	1. Policy on management of soiled linen.		
		2. Soiled linen is collected in dedicated colour coded linen bag as observed on inspection.		
		3. Adequate supply of alginate bag for contaminated linen		
	Facility Comments:			
12B.4.6.3	Soiled linen from infectious patients is clearly identified; staff shall take appropriate precautions in handling and processing this type of linen.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Policy on handling contaminated linen				
		2. Use of colour coded linen bag for different types of linen				
		3. Use of alginate bag for contaminated linen as evidenced on site				
	Facility Comments:					
12B.4.6.4	Written procedures are in accordance with acceptable standards for handling and processing linen and shall cover the following:					
	a) processing techniques including handling and collecting of dirty linen and transporting prior to washing;					
	b) physical appearance and condition of linen.					
	EVIDENCE OF COMPLIANCE	1. Policies and Procedures on Linen Services that address but not limited to items (a) to (b) are available.				
12B.4.6.6	Facility Comments:					
	EVIDENCE OF COMPLIANCE	1. Policy on transporting and storing of clean linen				
		2. Schedule on cleaning containers used for transporting clean linen.				
		3. Records on cleaning containers used for transporting clean linen.				
		4. Dedicated clean linen storage area.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 12B.5:		<u>SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES</u>				
STANDARD 12B.5.1		<i>The Head of Ophthalmology Ambulatory Care Services/Centre shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Ambulatory Care Services/Centre. The Head of Ophthalmology Ambulatory Care Services shall ensure compliance to monitoring of specific performance indicators.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
12B.5.1.1	The Head of the Ophthalmology Ambulatory Care Services/Centre shall ensure the provision of high quality performance through ongoing patient safety, quality improvement and risk management programmes of the Facility.					
	EVIDENCE OF COMPLIANCE	1. Plans for patient safety, quality improvement and risk management.				
	Facility Comments:					
12B.5.1.2	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Ophthalmology Ambulatory Care Services. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.					
	EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to (f)				
		2. Records on performance improvement activities				
		3. Minutes of performance improvement meetings				
		4. Performance improvement studies				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		5. Mortality and morbidity audits with remedial actions				
		6. Records on innovation if available.				
	Facility Comments:					
12B.5.1.3	The Head of Ophthalmology Ambulatory Care Services/Centre has assigned the responsibilities for planning, monitoring and managing safety and performance improvement activities to appropriate individual/personnel within the respective services.					
	EVIDENCE OF COMPLIANCE	1. Minutes of meetings				
		2. Letter of assignment of responsibilities				
		3. Job description				
	Facility Comments:					
12B.5.1.4	The Head of the Ophthalmology Ambulatory Care Services/Centre shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility.					
	Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.					
	EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:				
		a) Training of staff				
		b) Policy on incident reporting				
		c) Methodology of incident reporting				
		d) Register/records of incidents				
		2. Completed incident reports				
		3. Root Cause Analysis				
		4. Corrective and preventive action plans				
		5. Remedial measure				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		6. Minutes of meetings				
		7. Acknowledgment by Head of Service and PIC/Hospital Director				
		8. Feedback given to staff regarding incident reporting.				
	Facility Comments:					
12B.5.1.5 CORE	The Ophthalmologist Ambulatory Care Services/Centre shall address Patient Safety Goals to prevent potential errors from occurring. <u>World Health Organization (WHO) Global Patient Safety Challenges</u> 1. Identify patient correctly 2. Improve effective communication 3. Improve the safety of high-alert medications 4. Ensure correct-site, correct-procedure, correct-patient surgery 5. Reduce the risk of healthcare associated infections 6. Reduce the risk of patient harm resulting from fall <u>World Health Organization (WHO) Patient Safety Solutions</u> 1. Look-Alike, Sound-Alike Medication Names 2. Patient Identification 3. Communication During Patient Hand-Overs 4. Performance of Correct Procedure at Correct Body Site 5. Single Use of Injection Devices 6. Improved Hand Hygiene to Prevent Healthcare Associated Infections <u>Malaysian Patient Safety Goals</u> 1. To implement Clinical Governance 2. To implement the WHO's 1st Global Patient Safety Challenge: "Clean Care is Safer Care" 3. To implement the WHO's 2nd Global Patient Safety Challenge: "Safe Surgery Saves Lives" 4. To improve the accuracy of patient identification 5. To ensure medication safety 6. To improve clinical communication by implementing critical value programme 7. To reduce patient fall 8. To implement an Incident Reporting and Learning System					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Report on implementation of WHO Global Patient Safety Challenges & Patient Safety Solutions and Malaysian Patient Safety Goals.				
	Facility Comments:					
12B.5.1.5 CORE	There is tracking and trending of specific performance indicators of the following:					
	a) Percentage infectious endophthalmitis following cataract surgery (Target: $\leq 0.2\%$, 2 cases per 1000 operations)					
	b) Percentage of patients with post-operative visual acuity of 6/12 or better within 3 months following cataract surgery and refractive procedure in patients without ocular co-morbidity (Target: $>85\%$)					
	EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored.				
		2. Records on tracking and trending analysis.				
		3. Remedial measures taken where appropriate.				
	Facility Comments:					
12B.5.1.6	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.					
	EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff.				
		2. Evidence of feedback via communication on results of performance improvement activities through continuing medical education/meetings.				
		3. Minutes of service/unit/committee meetings				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
12B.5.1.7	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.					
	EVIDENCE OF COMPLIANCE	1. Documentation on performance improvement activities and performance indicators.				
		2. Policy statement on anonymity on patients and providers involved in performance improvement activities.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT	
TOPIC 12B.6	SPECIAL REQUIREMENTS
STANDARD 12B.6.1	<u>Waste Management</u> <i>The disposal of domestic, clinical and recycled wastes is carried out in accordance with legislation requirements of the Department of Environment and local authority.</i>

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
12B.6.6.1	<u>Waste management</u> a) Waste disposal shall be in accordance with national and local regulations. Waste generated by the sterilising supply services shall be placed in appropriate containers/bags. b) All contaminated waste such as: i) soiled surgical dressings, e.g. cotton wool, gloves, swabs; ii) human tissue shall be discarded into appropriate containers and disposed in accordance with the regulatory requirements. c) Used vials of biological indicators for monitoring of sterilisation shall be disposed in accordance with the regulatory requirements. d) Appropriate size of sharps containers shall be provided for disposal of condemned needles, used single needles and syringes, blades and other disposable sharp items. The collection container must be puncture resistant and leak tight. This category of waste has to be disposed/destroyed completely as to prevent potential risk of injury/infection. e) All clinical waste should be removed from the operating theatre and sterilising supply services via a designated disposal exit for incineration. f) Availability of hand washing facilities in storage area.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	EVIDENCE OF COMPLIANCE	1. Policy on segregation, collection and storage of waste					
		2. Planned schedule for waste disposal by facility/centre					
		3. Dedicated route					
		4. Record of waste collection					
		5. Contract for clinical waste disposal					
	Facility Comments:						
12B.6.6.2	Cytotoxic wastes shall be segregated at the point of origin, appropriately labelled during collection in compliance with the relevant regulations and guidelines, collected in approved colour-coded bags by appropriately trained staff, stored in designated storage facility with proper temperature controls, and with hand washing facility and wastewater drainage.						
	EVIDENCE OF COMPLIANCE	1. Cytotoxic wastes are properly labelled and not mixed with other wastes.					
		2. Appropriate storage facilities for cytotoxic wastes.					
		3. Spillage kits					
	Facility Comments:						
12B.6.6.3	Staff that handle chemicals and healthcare facility wastes need to be trained on proper handling and disposal of such wastes.						
	EVIDENCE OF COMPLIANCE	1. Records on staff training					
	Facility Comments:						
12B.6.6.4	Staff shall wear appropriate personal protective equipment when handling hazardous materials.						

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Staff and contractors wear appropriate personal protective equipment.				
	Facility Comments:					
12B.6.6.5	Chemicals and healthcare wastes shall be appropriately stored as follows:					
	a) inflammable, acid/base chemicals shall be kept separately in metal cabinets;					
	b) the chemical and scheduled waste store shall be well ventilated and equipped with spillage containment;					
	c) the clinical waste store shall be refrigerated if the wastes are stored for more than 24 hours.					
	EVIDENCE OF COMPLIANCE	1. Proper storage of chemicals in appropriate and right size cabinets and/or rooms.				
		2. Clinical waste store is refrigerated at temperature 4°C - 6°C if the wastes are stored for more than 24 hours.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
STANDARD 12B.6.2		<i>FIRE SAFETY</i> <i>The buildings of Ophthalmology Ambulatory Care Services shall be designed, constructed, equipped, operated and maintained in compliance with the relevant Acts, Statutory Regulations and Standards, ensuring safety to patients, visitors, staff and property from damages due to fire.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
12B.6.2.1	The building shall be equipped with active and passive fire protection system such as fire detection and suppression system, in compliance with statutory regulations, standards and professional best practices relating to fire safety. For buildings built after 1990, the fire detection systems shall be integrated and linked to the nearest fire station designated by the Fire Authority. <i>Note: Refer to Fire Services Act 1988</i>					
	EVIDENCE OF COMPLIANCE	1. Building drawing approved by Fire Authority for buildings built after 1990.				
		2. Continuous Monitoring Information System (CMIS) is functional and linked to the fire station where applicable.				
Facility Comments:						
12B.6.2.2	There is documented evidence that all buildings have been inspected by the Fire Authority annually and all risk issues identified during the inspections have been rectified to the satisfaction of the Fire Authority concerned. <i>Note: Refer to Fire Service Act 1988</i>					
	EVIDENCE OF COMPLIANCE	1. Annual fire inspection report by Fire Authority				
		2. Current Fire Safety Certificate is available for buildings built after 1990.				
		3. Facility's report on rectification of recommendations by Fire Authority where required.				
Facility Comments:						

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
12B.6.2.3	Fire fighting equipment/system, such as fire extinguishers, hydrants, hose reels, fire blankets and fire suppression system are located at appropriate locations as per Fire Authority's requirements.			
	The systems are in proper functioning condition, and are being maintained and tested regularly, at least once every three (3) months or as required.			
	EVIDENCE OF COMPLIANCE			
	1. Fire extinguishers have valid inspection certificates.			
	2. Testing of fire extinguishers			
	3. Maintenance records			
	Facility Comments:			
12B.6.2.4	There are clear signages to indicate the location of fire fighting equipment and general instructions to use the equipment during emergency.			
	EVIDENCE OF COMPLIANCE			
	1. Signages indicating fire fighting equipment are clearly visible.			
	Facility Comments:			
12B.6.2.5	All doors, corridors, ramps, and emergency stairways along the designated fire escape routes shall be kept free of obstruction at all times.			
	EVIDENCE OF COMPLIANCE			
	1. Fire exit routes are unobstructed.			
	Facility Comments:			
12B.6.2.6	All fire escape routes and fire exit doors shall be identified with lighted "KELUAR" or "EXIT" sign as stipulated in the Fire Authority's regulations.			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. <i>KELUAR</i> / EXIT signs are:			
		a) clearly visible;			
		b) functional;			
		c) adequate.			
	Facility Comments:				
12B.6.2.7	EVIDENCE OF COMPLIANCE	1. Current evacuation plans are available.			
		2. Clear signage to assembly areas			
	Facility Comments:				
12B.6.2.8	EVIDENCE OF COMPLIANCE	1. No Smoking” signs are:			
		a) visible;			
		b) adequate;			
		c) placed at all entrances to the Facility.			
	Facility Comments:				
12B.6.2.9	There is at least one designated Fire Safety Officer assigned by the Person In Charge. The Fire Safety Officer(s) shall have the relevant training to ensure that they can be responsible for fire safety at the Facility all times.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Assignment letter				
		2. Training records				
		3. Minutes of fire safety meetings				
		Facility Comments:				
12B.6.2.10	There is documented evidence that fire drills have been planned for every year, and the drills are held; minimum once in the current year, involving different sections of the service and conducted under varied conditions. There are written reports and evaluations on all drills, and documentation of staff attendances.					
	EVIDENCE OF COMPLIANCE	1. Records and reports on annual fire drills				
		2. Staff attendance list				
	Facility Comments:					
12B.6.2.11	The general contingency plan for fire and evacuation shall be understood by all staff and in-house contractors and tenants. Key assigned personnel shall be trained in more advanced aspects of fire safety, including fire notification procedures, fire alarm, use of fire fighting equipment, fire evacuation procedures and evacuation of non-ambulant patients.					
	EVIDENCE OF COMPLIANCE	1. Staff awareness on fire and evacuation plan				
		2. Records on training of key assigned personnel and staff on specific aspects of fire safety				
	Facility Comments:					
SURVEY ITEM & SELF-ASSESSMENT						

STANDARD 12B.6.3	DISASTER MANAGEMENT				
There shall be a disaster management system that supports safe practice and a safe environment:					
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
12B.6.3.1	The Facility/Centre shall have documented internal disaster plan for all anticipated occurrence of incidences that would have adverse effect on patients, visitors and staff as follows, where applicable: a) Fire/Explosion b) Bomb threat c) Evacuation d) Physical Assault/Security Threat e) Facilities system failure f) Major chemical spillage/radiation leaks g) Medical Emergencies h) Emergencies in Operating Rooms i) Flood j) Disease outbreak				
EVIDENCE OF COMPLIANCE	1. Internal Disaster Plan that include potential internal disasters (a) to (j)				
	2. List of relevant agencies and their contact numbers				
	3. Adequate resources as per disaster plan				
	4. Records on relevant staff training on the Internal Disaster Plan				
	5. Reports on the Internal Disaster Drill that carry out once a year.				
Facility Comments:					
12B.6.3.2	A code system normally using colour as identifier is used to identify the emergency status to avoid unnecessary panic if the code is announced via public address system.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Specified colour codes for internal disaster				
	Facility Comments:					

SURVEYOR SUMMARY:

OVERALL RISK:

SURVEY ITEM & SELF-ASSESSMENT

SERVICE STANDARD 13 : CRITICAL CARE SERVICES – ICU/CCU/CICU/CRW/HDU/BURNS CARE UNIT

PREAMBLE

Critical Care Services are provided in a specially staffed and equipped, separate and self-contained area of a hospital dedicated to the management of patients with life-threatening illnesses, injuries and complications, and monitoring of potentially life-threatening conditions. These services include Intensive Care Units (ICU), Coronary Care Units (CCU) and Burns Care Units.

An Intensive Care Unit provides comprehensive care for critically ill patients, e.g. those with multiple organ failure.

A Coronary Care Unit provides specialised care for critically ill patients with acute cardiac diseases.

A Burns Care Unit provides specialised care for critically ill patients with extensive and serious burn injuries.

Levels of Intensive Care Units

Each ICU should declare the level of intensive care it provides which should be consistent with the Facility's overall mission.

There are three levels of care described for Intensive Care Units (Reference: Marilyn T. Haupt et al. Guidelines on critical care services and personnel: Recommendations based on a system of categorisation of three levels of care. Critical Care Medicine 2003). These three levels of care are also applicable to Coronary Care Units and Burns Care Units.

Level 1 - This is equivalent to the 'High Dependency Unit (HDU)'. The unit shall be able to provide basic hemodynamic support, monitoring and oxygen therapy or non-invasive ventilation in a stable patient. The nurse to patient ratio shall be 1:2.

Level 2 - This unit shall be able to provide mechanical ventilation and invasive hemodynamic monitoring. An anesthetist/intensivist shall spend full time in the unit to manage all patients in the unit. The nurse to patient ratio shall be 1:1 for ventilated patients and 1:2 for non-ventilated patients

Level 3 - This unit shall be able to provide advanced mechanical ventilation, advanced hemodynamic monitoring and extracorporeal organ support, eg extracorporeal renal support, extracorporeal liver support, extracorporeal membrane oxygenation etc. Operating this unit as a "closed" unit is directed by an intensivist who shall spend full time in the unit to manage all patients in the unit. The nurse to patient ratio shall be 1:1 in every shift or more in highly complex cases.

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 13.1:		<u>ORGANISATION AND MANAGEMENT</u>				
STANDARD <u>13.1.1</u>		<i>The Critical Care Services (CCS) shall be organised to provide safe, efficient, and effective critical care services in accordance to the identified level of care.</i> <i>Identification of the level of care is by the Facility. The level of care identified shall be in tandem with the actual level of care provided in terms of all aspects of care, i.e. organisation, human resource, policies, facilities and performance improvement activities.</i>				
		CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
13.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Critical Care Services are clearly documented and measurable that indicates safety, quality and patient centred care. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.				
		2. Goals and objectives of the Critical Care Services in line with the Facility statements are available, endorsed and dated.				
		3. Evidence of planned reviews of the above statements.				
		4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)				
		5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.				
	Facility Comments:					
13.1.1.2 CORE	There is an organisation chart which: a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head of Critical Care Unit, consultants, medical practitioners and staff of the Critical Care Unit;					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS				
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING			
	b) is accessible to all staff and clients; c) includes off-site services if applicable; d) is revised when there is a major change in any of the following: i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns.						
	EVIDENCE OF COMPLIANCE				1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head of the Critical Care Unit, consultants, medical practitioners and staff of the Critical Care Unit.		
					2. Organisation chart of the service is endorsed, dated and accessible.		
					3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).		
	Facility Comments:						
13.1.1.3	Regular staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Critical Care Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.						
	EVIDENCE OF COMPLIANCE				1.Minutes are accessible, disseminated and acknowledged by the staff.		
					2.Attendance list of members with adequate representative of the services.		
					3.Frequency of meetings as scheduled.		
					4.Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).		
	Facility Comments:						
13.1.1.4	The head of each Critical Care Service (CCS) is involved in the planning, justification and management of the budget and resource utilization of the services.						

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes of Facility-wide management meeting.				
		2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service.				
		3. Approved budget and resources.				
	Facility Comments:					
13.1.1.5	The Head of each CCS is involved in the appointment and/OR assignment of the staff.					
	EVIDENCE OF COMPLIANCE	1. Records on staff interview (if applicable)				
		2. Appointment/assignment letter of Head of Service				
		3. Job description of Head of Service				
		4. Records on staff deployment				
		5. Duty roster				
	Facility Comments:					
13.1.1.6	Appropriate statistics and records shall be maintained in relation to the provision of Critical Care Services and used for managing the services and patient care purposes. For Level 2 and 3 Care, participation in Malaysian Registry of Intensive Care or similar that allows calculation of the standardized mortality ratio (SMR) and bench marking with other units is desirables.					
	EVIDENCE OF COMPLIANCE	1. Data are available but not limited to the following:				
		a) Number of cases, age, in-unit length of stay, in-unit mortality, bed occupancy rate, SMR;				
		b) Annual report;				
		c) Accident/incident reports;				
		d) Number of staff and staff profile;				
		e) Staff training and human resource records;				
		f) Data on performance improvement activities, including performance indicators.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 13.2:		<u>HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT</u>				
STANDARD 13.2.1		<i>The Critical Care Services (CCS) are appropriately and adequately staffed to achieve their goals and objectives.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
13.2.1.1 CORE	The Head and staff of the Critical Care Services (CCS) shall be individuals qualified by education, training, experience and certification to commensurate with the requirements of the various positions. For all levels of care of Critical Care Services, the Head of CCS is a clinician appointed to take overall responsibility for the operation of the unit. a) For Level 1 Care: A clinician shall be responsible for the management of the patient. b) For Level 2 Care: Anaesthetist/Intensivist shall spend full time in the unit and be responsible for the management of all patients in the unit. c) For Level 3 Care: Intensivist shall spend full time in the unit and be responsible for the management of all patients in the unit.					
	EVIDENCE OF COMPLIANCE	1. The clinician, anaesthetist or intensivist has a valid professional Annual Practising Certificate (APC) and appropriate National Specialist Registration.				
		2. For Level 1 Care, the Head is a clinician, appointed and responsible for the operation of the unit and management of all patients in the unit.				
		3. For Level 2 Care, the Head is an anaesthetist/intensivist rostered full time in the unit and responsible for the operation of the unit and management of all patients in the unit.				
		4. For Level 3 Care, the Head is an intensivist rostered full time in the unit and responsible for the operation of the unit and management of all patients in the unit.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
13.2.1.2	The authority, responsibilities and accountabilities of the Head of Critical Care Services are clearly delineated and documented.					
	EVIDENCE OF COMPLIANCE	1. Appointment/assignment letter for Head of Service.				
		2. Description of duties and responsibilities				
	Facility Comments:					
13.2.1.3 CORE	Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the need of the services as follows: a) a resident medical officer trained in anaesthesia/ICU is appointed to be predominantly present in the unit after office hours for Level 2 and 3 ICUs b) a nursing sister in-charge of the unit is appointed and has qualification in post basic nursing appropriate for the unit; c) a nursing staff with post basic appropriate for the unit is in-charge of the unit each shift; d) minimum percentage of nurses trained in intensive care nursing in the unit: 30% for Level 2 Care and 50% for Level 3 Care; e) nurse/patient ratio of 1:1 for ventilated patient; f) nurse/patient ratio of 1:2 for non-ventilated patient; g) a biomedical technician is available on 24 hour basis; h) cleaning personnel familiar with ICU environment and infection control/ environmental cleaning protocols (Ref: Consensus Statement on Infection Control Measures in ICU) are available on 24 hour basis; i) for Level 2 and 3 Care, physiotherapist and dietitian are available during working hours.					
	EVIDENCE OF COMPLIANCE	1. Number of staff and qualification should commensurate with workload and includes items (a) to (g).				
		2. Staffing pattern				
		3. Duty roster of medical officer trained in anaesthesia/ICU and nursing staff				
		4. Duty roster of physiotherapist and dietitian in Level 2 and 3 Care				
		5. Census and statistics				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	Facility Comments:				
13.2.1.4	There are written and dated specific job descriptions for all categories of staff that include: a) qualifications, training, experience and certifications required for the position; b) lines of authority; c) accountability, functions and responsibilities; d) reviewed when required and when there is a major change in any of the following: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations. e) administrative and clinical functions.				
	EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (g). 2. Job description includes specialisation skills 3. Relevant privileges granted where applicable 4. The job description is acknowledged by the staff and signed by the Head of Service and dated.			
	Facility Comments:				
13.2.1.5	Personnel records on training, staff development, leave and others are maintained for every staff. Note: Staff personal record may be kept in Human Resource Department as per Facility policy.				
	EVIDENCE OF COMPLIANCE	1. Staff personal records include: a) staff biodata; b) qualification and experience; c) evidence of current registration (Annual Practising Certificate, National Specialist Register, etc); d) training record;			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		e) competency record and privileging;				
		f) leave record;				
		g) confidentiality agreement;				
		Facility Comments:				
13.2.1.6	There is a structured orientation programme for all newly appointed staff to the Critical Care Services including medical practitioners and for those new to specific areas that include the following: a) explanation of the goals, objectives, policies and procedures of the Facility and those of the Critical Care Services; b) lines of authority and areas of responsibility; c) explanation of particular duties and functions; d) explanation of the methods of assigning clinical care and the standards of clinical practice; e) hand over communication; f) processes for resolving practice dilemmas; g) information about safety procedures; h) training in basic/advanced life support techniques; i) methods of obtaining appropriate resource materials; j) staff appraisal procedures for the Critical Care Services; k) education on Patient and Family Rights; l) education on MSQH Standards requirements.					
	EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme.				
		2. There is Critical Care Services orientation programme with relevant topics not limited to topics covered from (a) to (l).				
		3. Attendance list				
		Facility Comments:				
13.2.1.7	There is evidence of training needs assessment and staff development plan which provides the knowledge and skills required for staff to maintain competency in their current positions and future advancement.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and gaps identified.				
		2. A staff development plan based on training needs assessment is available.				
		3. Training schedule/calendar is in place.				
		4. Training module				
	Facility Comments:					
13.2.1.8	There are continuing education activities for staff including medical practitioner to pursue professional interests and to prepare for current and future changes in practice.					
	EVIDENCE OF COMPLIANCE	1. Training calendar includes in-house/external courses/ workshop/conferences				
		2. Contents of training programme				
		3. Training records on continuing education activities are kept and maintained for each staff.				
		4. Certificate of attendance/degree/post basic training.				
	Facility Comments:					
13.2.1.9 CORE	Clinical staff including medical practitioners working in the Critical Care Services have: a) specific specialised skills such as Basic Life Support and Advanced Life Support, b) a system of ongoing re-certification.					
	EVIDENCE OF COMPLIANCE	1. Staff training records and yearly training plan				
		2. Certification in basic life support, advanced life support and re-certification				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
13.2.1.10	Staff including medical practitioners receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.			
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff including medical practitioners is completed upon probationary period and as an annual exercise.		
	Facility Comments:			

SURVEY ITEM & SELF-ASSESSMENT				
TOPIC 13.3:		<u>POLICIES AND PROCEDURES</u>		
STANDARD <u>13.3.1</u>		<i>There are written and dated policies and procedures for all the activities of the Critical Care Services. These policies and procedures reflect current standards of Critical Care Services practices, relevant regulations, requirements of statutory authorities, and the goals and objectives of the services.</i>		
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT
		SURVEYOR RATING		
13.3.1.1 CORE	There are written policies and procedures for the Critical Care Services which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated. There is a mechanism for and evidence of a periodic review at least once in every three years.			
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for the service.		
		2. Policies and procedures are consistent with the regulatory requirements and current standard practices.		
		3. Evidence of periodic review of policies and procedures.		
		4. The policies and procedures are endorsed and dated.		
	Facility Comments:			
13.3.1.2	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved. Cross departmental collaboration is practised in developing relevant policies and procedures where applicable. These policies and procedures are consistent with current international standards for critical care services.			
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.		
		2. Minutes of meeting with evidence of cross reference with other departments		
		3. Documented cross departmental policies		
	Facility Comments:			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
13.3.1.3 CORE	A policy and procedure manual is kept up to date and is readily accessible to all staff and medical practitioners. There is evidence of compliance with the policy and procedure manual. The manual shall include but not limited to the following: a) operational policy; b) admission, discharge and referral policy; c) visitation policy; d) credentialing and privileging on special procedures, e.g. mechanical ventilation, renal replacement therapy; e) clinical management protocol, e.g. weaning from mechanical ventilation, thromboprophylaxis, etc; (Ref: ICU Management Protocols 2019, Ministry of Health, Malaysia) f) drug administration; g) procedural policy, e.g. central line catheterisation; h) antibiotic policy; i) infection control; j) needle stick injury; k) transport of patients; l) withholding and withdrawal of therapy; (Ref: Communication in intensive care manual available at the Academy of Medicine) m) organ donation;				
	EVIDENCE OF COMPLIANCE	1. Presence of policy and procedure manual that include (a) to (m).			
		2. Verification of staff practice on compliance with policies and procedures upon on-site observation.			
		3. Review of patient notes on usage of antibiotics, thromboprophylaxis, stress ulcer prophylaxis, etc.			
	Facility Comments:				
13.3.1.4 CORE	There is evidence of implementation of written policies and procedures of each critical care unit.				
	EVIDENCE OF COMPLIANCE	1. Compliance with policies and procedures through: -			
		a) interview of staff on practices;			
		b) verify with observation on practices;			
		c) results of audit on practices;			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	d) practices in line with established policies and procedures.				
	Facility Comments:				
13.3.1.5	There is evidence of compliance with a minimum of two (2) evidence based guidelines, e.g. Clinical Practice Guidelines (CPG) on management of Dengue infection in adults, Surviving Sepsis Campaign international guidelines on the management of severe sepsis and septic shock, CPG on Unstable Angina/Non-ST Elevation Myocardial Infarction (UA/NSTEMI), etc.				
	EVIDENCE OF COMPLIANCE	1. Compliance with evidence based guidelines through:-			
		a) interview of staff on practices;			
		b) verify with observation on practices;			
		c) results on audit on practices;			
		d) practices in line with evidence based guidelines			
	Facility Comments:				
13.3.1.6	Current policies and procedures are communicated to all staff.				
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings			
		2. Circulation list and acknowledgement			
	Facility Comments:				
13.3.1.7	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.				
	EVIDENCE OF COMPLIANCE	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 13.4:		<u>FACILITIES AND EQUIPMENT</u>				
STANDARD 13.4.1		<i>There are appropriate and adequate physical facilities and equipment for the efficient operations of the critical care services.</i>				
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
13.4.1.1	The Critical Care Services shall be provided in a discrete area close to areas which have the greatest requirements for its services such as operating theatres, Emergency Department, Radiology/Diagnostic Imaging Services etc.					
	EVIDENCE OF COMPLIANCE	1. The Critical Care Services shall be provided in a discrete area with easy access to operating theatres, Emergency Department, Radiology/Diagnostic Imaging Services etc				
	Facility Comments:					
13.4.1.2 CORE	There are adequate and appropriate facilities and equipment with proper utilisation of space to enable staff to carry out their professional, teaching and administrative functions.					
	EVIDENCE OF COMPLIANCE	1. Adequate and proper utilisation of space as per regulatory requirements.				
		2. Appropriate type of equipment to match the complexity of services.				
		3. Adequate facilities and equipment at each patient care area for safe care (e.g. defibrillators, emergency cart, handwashing facilities, etc).				
		4. Easy access and clear exit routes				
		5. Absence of overcrowding				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
13.4.1.3	The immediate physical environment of the patient is as unobtrusive and as aesthetically pleasing as possible.				
	EVIDENCE OF COMPLIANCE	1. Physical environment of the patient is unobtrusive as observed on-site.			
	Facility Comments:				
13.4.1.4 CORE	There shall be adequate facilities for infection control in the unit such as: a) sinks with elbow/foot operated faucets; b) hand-drying facility, e.g. disposable paper towels; c) alcohol-based hand rub per bed; d) separate clean and dirty utility rooms; e) endotracheal suctioning via a closed system or a single use disposable catheter.				
	EVIDENCE OF COMPLIANCE	1. Infection control facilities in each unit include (a) to (e) as observed on site.			
	Facility Comments:				
13.4.1.5	There shall be provision for isolation of different categories of patients, e.g. those with airborne infectious diseases. Reference: a) Isolation room with its own wash basin, en-suite, ante room of at least 2.5 m² and control of airflow b) Level 2 Care: Negative pressure isolation room; c) Level 3 Care: Ratio of isolation room to number of beds 1:6 (one single negative pressure isolation room for every six beds in the unit).				
	EVIDENCE OF COMPLIANCE	1. Isolation rooms appropriate to the level of care provided are available.			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
13.4.1.6	There are separate areas for the sanitation and storage of equipment.					
	EVIDENCE OF COMPLIANCE	1. Separate areas for sanitation and storage of equipment as observed upon site inspection.				
	Facility Comments:					
13.4.1.7	There are facilities for patients, relatives and staff which include: a) counselling room for relatives; b) rest room for staff; c) room for distressed relatives; d) waiting area for relatives.					
	EVIDENCE OF COMPLIANCE	1. Presence of facilities for relatives and staff include (a) to (d) as observed on site.				
	Facility Comments:					
13.4.1.8 CORE	The Critical Care Services shall have 24-hour access to on-site laboratory services such as: a) point of care testing, e.g. blood gas, glucose, etc.; b) laboratory test results i.e. full blood count, urinalysis, biochemistry (electrolytes, urea, creatinine, calcium), coagulation profile and lactate are available within 1 hour for review and action; c) laboratory test results i.e. osmolality, serum magnesium and phosphorus and toxicology screening are available within 3 hours for review and action d) culture and Gram-stain results are available 24 hours per day.					
	EVIDENCE OF COMPLIANCE	1. Blood gas machine is available and functional in the unit.				
		2. Records on maintenance of blood gas machine				
		3. Quality control of blood gas machine				
		4. Laboratory results are available within the timeframe, reviewed, signed and plan of action written down				
		5. Availability of culture results 24 hours per day				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
13.4.1.9 CORE	The Critical Care Services shall have 24-hour access to Radiology/Diagnostic Imaging Services and blood bank services.				
EVIDENCE OF COMPLIANCE	1. Evidence from interview of staff/records on availability of 24-hour access to Radiology/Diagnostic Imaging Services and blood bank services				
Facility Comments:					
13.4.1.10 CORE	There are adequate numbers of vacuum outlets, oxygen and compressed air outlets, and suction facilities as well as properly grounded electrical outlets with duplicate or independent circuits available to every patient. Reference: a) Minimum 12 electrical outlets per bed for Level 1 Care b) Minimum 16 electrical outlets per bed for Level 2 and 3 Care c) Minimum 2 vacuum outlets per bed for Level 2 Care d) Minimum 3 vacuum outlets per bed for Level 3 Care e) Minimum 2 oxygen outlets per bed for Level 2 Care f) Minimum 3 oxygen outlets per bed for Level 3 Care g) Minimum 2 compressed air outlets per bed for Level 2 Care h) Minimum 3 compressed air outlets per bed for Level 3 Care				
EVIDENCE OF COMPLIANCE	1. The number of vacuum outlets, oxygen, compressed air outlets and suction facilities commensurate with the complexities of services provided.				
Facility Comments:					
13.4.11 CORE	The beds are readily adjustable to various therapeutic positions, easily moved for transport and with locking mechanisms for a secure stationary position, side-rails, and removable headboard.				
EVIDENCE OF COMPLIANCE	1. All the beds are functional as per standard requirement.				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	Facility Comments:				
13.4.1.12 CORE	The equipment for monitoring as well as intervention shall be appropriate to the Level of Care provided by the unit as follows: a) For Level 1 Care, monitoring equipment with trending capability and visible and audible alarms with simultaneous display of electrocardiography (ECG), non-invasive pressure, temperature and pulse oximetry; b) For Level 2 and 3 Care, monitoring equipment with modular systems, trending capability and visible and audible alarms with simultaneous display of 4 waveforms and selectable digital values for ECG, non-invasive pressure, temperature, pulse oximetry, arterial pressure, central venous pressure, intra-cranial pressure and capnography.				
	EVIDENCE OF COMPLIANCE	1. All the above listed facilities and equipment for the level of care provided are available as in (a) to (b) and functional.			
	Facility Comments:				
13.4.1.13	Facilities and equipment are appropriate to the Services and shall include the following: a) uninterrupted power supply system; b) central air conditioning system which allows control of temperature, humidity and air exchange according to relevant standards. Recirculated air shall pass through appropriate filters with 99% filtration efficiency; c) an alarm system for Critical Care Services personnel to summon additional staff in an emergency; d) variable lighting systems for day and night mode and high illumination and spot lighting for procedures; e) alternate emergency lighting, gas and power sources or other appropriate mechanisms available to operate all life support systems including suction apparatus; f) adequate supplies of medications and intravenous fluids available 24 hours a day in the unit; g) hand ventilating assemblies; h) suction apparatus; i) vascular access equipment including access to ultrasound for placement of				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	intravascular catheters j) equipment to control patient temperature k) chest drainage equipment; l) portable transport equipment; m) lifting/weighing equipment including apparatus for mobilizing patients early out of bed, e.g. hoist, rehabilitation chair, walking frame (Ref: ICU Management Protocols 2019, Ministry of Health, Malaysia); n) sufficient number of volumetric and syringe pumps appropriate to the Level of Care; o) for Level 2 and 3 Care, invasive and non-invasive ventilators appropriate to the Level of Care provided; a) for Level 3 Care, renal replacement therapy services are available 24 hours per day.				
	EVIDENCE OF COMPLIANCE	1. All the above facilities and equipment are available and functional and include systems and facilities as listed in (a) to (n).			
		2. The minimum number of syringe pumps per bed are: Level 1 Care: 2 syringe pumps per bed Level 2 Care: 5 syringe pumps per bed Level 3 Care: 10 syringe pumps per bed			
		3. The number of invasive ventilators:			
		a) Level 2 Care: the invasive ventilators should have all the basic modes of mechanical ventilation			
		b) Level 3 Care: the invasive ventilators should have the advanced modes of mechanical ventilation, alarm systems and battery back-up			
	Facility Comments:				
13.4.1.14 CORE	All other emergency and life support equipment are readily accessible and functional, including airway access equipment to assist with management of the difficult airway				
	EVIDENCE OF COMPLIANCE	1. Emergency and life support equipment are available and functional as required.			
		2. Resuscitation trolley (1 per 8 beds), defibrillator and equipment to manage difficult airway.			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	Facility Comments:				
13.4.1.15	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.				
	EVIDENCE OF COMPLIANCE	1. Testing, commissioning and calibration records (certificates or stickers)			
		2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as evidence of compliance to the relevant standards and Acts.			
	Facility Comments:				
13.4.1.16	Expert advice concerning the safe use of and maintenance for all biomedical devices and electrical installations are readily available at all times. Documentation of safety testing is provided on a regular basis to the unit head.				
	EVIDENCE OF COMPLIANCE	1. Records on advisory service on safe use and maintenance of biomedical device and electrical installations.			
		2. User training records			
	Facility Comments:				
13.4.1.17 CORE	There is evidence that the facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.				
	EVIDENCE OF COMPLIANCE	1. Planned Preventive Maintenance records such as schedule, stickers, etc.			
		2. Planned Replacement Programme where applicable			
		3. Complaint records			
		4. Asset inventory			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
13.4.1.18 CORE	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.				
EVIDENCE OF COMPLIANCE	1. User training records				
	2. Competency assessment record				
	3. Letter of authorisation				
	4. List of staff trained and competent to operate specialised equipment				
Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT					
TOPIC 13.5:		<u>SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES</u>			
STANDARD 13.5.1		<i>The Head of Critical Care Services shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Critical Care Services.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
13.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Critical Care Services. The process includes: a) Planned activities to include ABCDEF bundle, ventilator care bundle, central venous catheter care bundle, pressure sore care bundle (SSKIN bundle), early mobility, end of life care b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.				
	EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to (f).			
		2. Records on performance improvement activities.			
		3. Minutes of performance improvement meetings.			
		4. Performance improvement studies			
		5. Mortality and morbidity audits with remedial actions.			
		6. Records on innovation if available.			
	Facility Comments:				
13.5.1.2	The Head of Critical Care Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement to appropriate individual/personnel within the respective services.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes of meetings				
		2. Letter of assignment of responsibilities				
		3. Job description				
	Facility Comments:					
13.5.1.3 CORE	The Head of the Critical Care Services shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility. Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.					
	EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:				
		a) Training of staff				
		b) Policy on incident reporting				
		c) Methodology of incident reporting				
		d) Register/records of incidents				
		2. Completed incident reports				
		3. Root Cause Analysis				
		4. Corrective and preventive action plans				
		5. Remedial measure				
		6. Minutes of meetings				
		7. Acknowledgment by Head of Service and PIC/Hospital Director				
		8. Feedback given to staff regarding incident reporting.				
		Facility Comments:				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
13.5.1.4 CORE	The Critical Care Services has Clinical Risk Management Programme that provides an appropriate peer group structure for performing the safety and performance improvement activities to accomplish clinical care evaluation.			
	a) The medical practitioners undertake clinical reviews of all risk assessments, incident reports, audits, safety and performance improvement activities:			
	i) in multidisciplinary committees within the Services;			
	ii) in a variety of purpose-specific committees, such as mortality and morbidity, blood transfusion and infection control.			
	b) Whatever structure is utilised, provision is made for review and analysis of the clinical work of each individual clinical service, unit or function.			
EVIDENCE OF COMPLIANCE	1. Risk Management Programme			
	2. Minutes of meetings			
	3. Relevant reports and documents, e.g. clinical audit reports, incident reports, mortality and morbidity review reports, etc.			
Facility Comments:				
13.5.1.5 CORE	There is tracking and trending of specific performance indicators not limited to but at least 5 of the following:			
	a) rate of pressure ulcers (Target: < 3%)			
	b) rate of unplanned extubation (Target: <5%)			
	c) rate of Ventilator Associated Pneumonia (VAP) (Target: < 10 per 1000 ventilator days)			
	d) rate of catheter related blood stream infection (Target: < 5 per 1000 catheter days)			
	e) compliance rate to hand hygiene (Target: >			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS				
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING			
	f) 75%) for Level 2 & 3 Care, standardized mortality ratio and benchmarking with other units								
	EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored.							
		2. Records on tracking and trending analysis.							
		3. Remedial measures taken where appropriate							
	Facility Comments:								
13.5.1.6	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.								
	EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff.							
		2. Evidence of feedback via communication on results of performance improvement activities through continuing medical education/meetings.							
		3. Minutes of service/unit/committee meetings							
	Facility Comments:								
13.5.1.7	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.								
	EVIDENCE OF COMPLIANCE	1. Documentation on performance improvement activities and performance indicators.							
		2. Policy statement on anonymity on patients and providers involved in performance improvement activities.							
	Facility Comments:								

SERVICE SUMMARY

SURVEYOR SUMMARY:

OVERALL RATING:

OVERALL RISK:

SURVEY ITEM & SELF-ASSESSMENT	
SERVICE STANDARD 13A : CRITICAL CARE – SCN/NICU/PICU/PHDW	
	<u>PREAMBLE</u> <u>CRITICAL CARE SERVICES – SCN/NICU/PICU/PHDW</u> <i>Critical Care Services for paediatric and neonatal cases are specialised care units within the paediatric services in a hospital designated to provide a higher level of care than a general paediatric ward. The scope of the services provided by the unit should be guided by the professional qualifications and experience of the clinicians and are expected to provide appropriate facilities, equipment and staff to safely and effectively care for children and neonates in need of the service.</i> <i>The units that fall within this category are:</i> 1. <i>Paediatric Critical Care Services:</i> a) <i>Paediatric Intensive Care Units (PICU)</i> b) <i>Paediatric High Dependency Unit (PHDU)</i> 2. <i>Neonatal Critical Care Services</i> a) <i>Special Care Nursery (SCN)</i> b) <i>Neonatal Intensive Care Units (NICU)</i> <i>Paediatric and Neonatal Critical Care Units provide comprehensive care for a wide range of complex, progressive and life-threatening or potentially life-threatening disorders in critically ill paediatric and neonatal cases, and may vary in the levels of care that are provided (depending on personnel and their level of expertise, physical characteristics, and facilities) and they may differ in the types of specialised care that are provided (e.g. paediatric, neonatal, cardiothoracic surgery, neurosurgery, transplantation, nephrology and others).</i> <u>Levels of Neonatal Care Units</u> <i>Each unit should declare the level of care it provides with respect to the delivery of critical care and this should be consistent with the Facility's overall mission.</i> <u>Level I - Neonatal care in postnatal wards</u>

	<i>This unit supplies normal postnatal beds for well babies who are placed together with their mothers and regarded as inpatients. Some of these babies will be receiving treatments for completion of antibiotics, continuation of phototherapy for mild neonatal jaundice or glucose monitoring. The unit is supervised by a separate set of nursing staff and doctors but requires only minimal medical or nursing care. This is to encourage breastfeeding and bonding for the babies.</i> <i>Level II - Special Care Beds and provides care in a speciality-level facility. This unit provides care for convalescent pre-term neonates, neonates requiring care for transitory problems not requiring sub-speciality level services on an urgent basis.</i> <i>Level II(a) (Low Dependency) Special Care beds:</i> <i>For convalescent preterm neonates, or neonates requiring observation for transient problems, phototherapy, investigatory procedures and frequent feeding</i> <i>Level II(b) (High Dependency) Special Care beds:</i> <i>For neonates requiring peripheral intravenous therapy, simplified cardiorespiratory monitoring, apnoea monitoring, oxygen not usually in excess of 40%, chronic oxygen dependency and surgical nursing</i> <i>Level III - This unit provides intensive care beds to neonates requiring sustained life support, i.e. assisted ventilation for intubated neonates, neonates requiring stabilisation pre and post major surgery and neonates requiring intensive monitoring.</i> <i>Level III(a) (Low Dependency) Intensive Care beds:</i> <i>For neonates requiring CPAP, continuous cardiorespiratory monitoring, intraarterial blood pressure monitoring, parenteral nutrition, central venous catheterisation, oxygen therapy in excess of 40%, acute surgical nursing</i> <i>Level III(b) (High dependency) Intensive Care beds:</i> <i>For neonates requiring endotracheal intubation for assisted ventilation, intraarterial blood pressure monitoring, continuous cardiorespiratory monitoring, parenteral nutrition, central venous catheterisation, transcutaneous blood gas and oxygen saturation monitoring and neonates requiring stabilisation following major surgery</i> <i>Level IV - Equivalent to level III capabilities plus ability to provide surgical repair for acquired or congenital disorders with a range of other subspecialties, i.e. paediatric medical subspecialties, paediatric anaesthesiology care and paediatric surgical subspecialties.</i> <i>(Based on Paediatric Services Operational Policy 2012 MOH/P/PAK/175.08 (BP))</i>

TOPIC 13A.1:	<u>ORGANISATION AND MANAGEMENT</u>
STANDARD 13A.1.1	<i>The SCN/NICU/PICU/PHDW shall be organised and administered to provide safe, efficient, and effective critical care services in accordance with the identified level of care.</i> <i>Identification of the level of care is by the Facility. The level of care identified shall be in tandem with the actual level of care provided in terms of all aspects of care, i.e. organisation, human resource, policies, facilities and performance improvement activities.</i>

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
13A.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Paediatric or Neonatal Critical Care Services are clearly documented and measurable that indicates safety, quality and patient centred care. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.			
	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.			
	2. Goals and objectives of the Paediatric or Neonatal Critical Care Services in line with the Facility statements are available, endorsed and dated.			
	3. Evidence of planned reviews of the above statements.			
	4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)			
	5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.			
	Facility Comments:			
13A.1.1.2 CORE	There is an organisation chart which: a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head of the Paediatric or			

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	Neonatal Critical Care Services, consultants, medical practitioners and staff of the Paediatric or Neonatal Critical Care Services; b) is accessible to all staff and clients; c) includes off-site services if applicable; d) is revised when there is a major change in any of the following: i)organisation; ii) functions; iii) reporting relationships; iv) staffing patterns.					
	EVIDENCE OF COMPLIANCE				1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head of the Paediatric and Neonatal Critical Care Services, consultants, medical practitioners and the rest of the staff.	
					2. Organisation chart of the service is endorsed, dated and accessible.	
					3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).	
	Facility Comments:					
13A.1.1.3	Regular staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Paediatric or Neonatal Critical Care Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.					
EVIDENCE OF COMPLIANCE	1. Minutes are accessible, disseminated and acknowledged by the staff.					
	2. Attendance list of members with adequate representatives of the service.					
	3. Frequency of meetings as scheduled.					
	4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	Facility Comments:				
13A.1.1.4	The Head of each of the Paediatric or Neonatal Critical Care Services (CCS) is involved in the planning, justification and management, of the budget and resource utilisation of the services.				
EVIDENCE OF COMPLIANCE	1. Minutes of Facility-wide management meeting				
	2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service.				
	3. Approved budget and resources.				
	Facility Comments:				
13A.1.1.5	The Head of a Paediatric or Neonatal CCS is involved in the appointment and/OR assignment of the staff.				
EVIDENCE OF COMPLIANCE	1. Records on staff interview (if applicable)				
	2. Appointment/assignment letter of Head of Service				
	3. Job description of Head of Service				
	4. Records on staff deployment				
	5. Duty roster				
	Facility Comments:				
13A.1.1.6	Appropriate statistics and records shall be maintained in relation to the provision of Paediatric or Neonatal Critical Care Services and used for managing the services and patient care purposes.				
EVIDENCE OF COMPLIANCE	1. Records are available but not limited to the following:				
	a) workload/census;				
	b) annual report;				
	c) accident/incident reports;				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		d) staffing number and staff profile;				
		e) staff training records;				
		f) data on performance improvement activities, including performance indicators relevant to each specific critical care				
		g) hand washing records, Central Line-Associated Bloodstream Infection (CLABSI) rates, nosocomial infection rates and mortality rates				
		h) Mortality Meetings				
		2. Statistics are used for managing services and patient care.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT							
TOPIC 13A.2:		<u>HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT</u>					
STANDARD <u>13A.2.1</u>		<i>The Paediatric and Neonatal Critical Care Services are appropriately and adequately staffed and directed to achieve their goals and objectives.</i>					
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
13A.2.1.1	The Head and staff of the Paediatric and Neonatal Critical Care Services shall be individuals qualified by education, training, experience and certification to commensurate with the requirements of the various positions.						
	EVIDENCE OF COMPLIANCE	1. Records on credentials of Head of Service and nursing staff required to fill up the posts within the service (to match the complexity of the services) and certification /registration(Annual Practising Certificate)					
		2. Experience of the Head and staff of Paediatric and Neonatal Critical Care Services meet the demand of their positions.					
		3. List of doctors/nurses with post basic certification in various disciplines.					
		4. Appointment/assignment letters					
		5. Training and competency records					
		6. Deployment/assignment according to staff speciality.					
		7. Qualified Community Nurse worked in Labour Room.					
	Facility Comments:						
13A.2.1.2	The authority, responsibilities and accountabilities of the Head of Paediatric or Neonatal Critical Care Services is clearly delineated and documented.						
	EVIDENCE OF COMPLIANCE	1. Appointment/assignment letter for Head of Service.					
		2. Description of duties and responsibilities					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	Facility Comments:			
13A.2.1.3 CORE	Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the need of the services. The number of staff required shall be based on accepted norms.			
	EVIDENCE OF COMPLIANCE	1. Number of staff and qualification should commensurate with workload.		
		2. Duty roster		
		3. Census and statistics		
		4. Staffing pattern		
		a) <u>Paediatric and Neonatal Intensive Care</u> Considering the complexities of care needed for a patient receiving intensive care, there should be 1:1 ratio of nursing staff. In cases, where the patient is particularly unstable, for example with severe pulmonary hypertension, two (2) nurses will be required.		
		b) <u>High Dependency Care</u> i. Paediatric - A nurse should not have responsibility for the care of more than two (2) patients ii. Neonatal - Special Care Nursery (Level IIa & IIb) A staff nurse should not have responsibility for the care of more than four (4) patients : (Based on Paediatric Services Operational Policy 2012 MOH/P/PAK/175.08 (BP))		
	Facility Comments:			

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
13A.2.1.4	There are written and dated specific job descriptions for all categories of staff that include: a) qualifications, training, experience and certifications required for the position; b) lines of authority; c) accountability, functions and responsibilities; d) reviewed when required and when there is a major change in any of the following: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations. e) administrative and clinical functions.			
	EVIDENCE OF COMPLIANCE			
	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e).			
	2. Job description includes specialisation skills			
	3. Relevant privileges granted where applicable			
	4. The job description is acknowledged by the staff and signed by the Head of Service and dated.			
	Facility Comments:			
13A.2.1.5	Personnel records on training, staff development, leave and others are maintained for every staff. Note: <i>Staff personal record may be kept in Human Resource Department as per Facility policy.</i>			
	EVIDENCE OF COMPLIANCE			
	1. Staff personal records include:			
	a) staff biodata;			
	b) qualification and experience;			
	c) evidence of current registration;			
	d) training record;			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		e) competency record and privileging;				
		f) leave record;				
		g) confidentiality agreement.				
	Facility Comments:					
13A.2.1.6	There is a structured orientation programme for all newly appointed staff to the Paediatric and Neonatal Critical Care Services including medical practitioners and for those new to specific areas that include the following: a) explanation of the goals, objectives, policies and procedures of the Facility and those of the Paediatric Critical Care Services; b) lines of authority and areas of responsibility; c) explanation of particular duties and functions; d) explanation of the methods of assigning clinical care and the standards of clinical practice; e) hand over communication; f) processes for resolving practice dilemmas; g) information about safety procedures; h) training in basic/advanced life support techniques; i) methods of obtaining appropriate resource materials; j) staff appraisal procedures for the Paediatric Critical Care Services; k) education on Patient and Family Rights; l) education on MSQH Standards requirements.					
	EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme. (Under governance – Hospital)				
		2. There is Paediatric and Neonatal Critical Care Services orientation programme with relevant topics not limited to topics covered from (a) to (l).				
		3. Attendance list				
	Facility Comments:					
13A.2.1.7	There is evidence of training needs assessment and staff development plan which provides the knowledge and skills required for staff to maintain competency in their current positions and future advancement.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and gaps identified.				
		2. A staff development plan based on training needs assessment is available.				
		3. Training schedule/calendar is in place.				
		4. Training module				
	Facility Comments:					
13A.2.1.8	There are continuing education activities for staff including medical practitioners to pursue professional interests and to prepare for current and future changes in practice.					
	EVIDENCE OF COMPLIANCE	1. Training calendar includes in-house/external courses/workshop/conferences				
		2. Contents of training programme e.g. Structured training programme for non-post basic nurses to be privileged to work in the intensive care area				
		3. Training records on continuing education activities are kept and maintained for each staff.				
		4. Certificate of attendance/degree/post basic training.				
		5. Plan for staff to enrol in post basic courses according to their eligibility, 40% of the ward staff should have post basic training in NICU/PICU/Paediatric Nursing.				
	Facility Comments:					
13A.2.1.9 CORE	Clinical staff including medical practitioners working in the Paediatric Critical Care Services have: a) specific specialised skills such as cardiopulmonary resuscitation (CPR), Advanced Cardiac Life Support (ACLS), Basic Life Support (BLS), Neonatal Resuscitation Programme (NRP), Paediatric Life Support (PLS), Advanced Paediatric Life Support (APLS); b) a system of ongoing re-certification.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Medical and nursing staff who work in the Paediatric Critical Care setting shall be proficient in resuscitation of paediatric patients.				
		2. Certification in specific cardiopulmonary resuscitation life support, Neonatal Resuscitation Programme (NRP), Paediatric Life Support (PLS), Advanced Paediatric Life Support (APLS) and re-certification.				
		3. Schedule of life support training for new and current staff				
	Facility Comments:					
13A.2.1.10	Staff including medical practitioners receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.					
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff including medical practitioners is completed upon probationary period and as an annual exercise.				
		Facility Comments:				
13A.2.1.11	Organisations should have arrangements for the: a) promotion of staff well-being b) resolution of workplace issues					
	EVIDENCE OF COMPLIANCE	1. The promotion of staff well-being may involve: a) procedures to promote well-being, e.g. stress management, workload monitoring, management of work life balance, healthy lifestyle programmes e.g. BookDoc, KOSPEN				
		b) staff being provided with appropriate supervision, support and advice e.g. Mentor Mentee				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		2. The resolution of workplace issues may involve: a) measures to protect staff against violence, bullying and harassment e.g. signage				
		b) clear procedures for the effective management of underperformance e.g. feedback on Sasaran Kerja Tahunan (SKT)				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT					
TOPIC 13A.3:		<u>POLICIES AND PROCEDURES</u>			
STANDARD 13A.3.1		<i>There are written and dated policies and procedures for all the activities of the Paediatric Critical Care Services. These policies and procedures reflect current standards of CCS practices, relevant regulations, requirements of statutory authorities, and the goals and objectives of the services.</i>			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	
				SURVEYOR RATING	
13A.3.1.1 CORE	There are written policies and procedures for the Critical Care Services which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated and shall include the following policies where applicable: a) Central Line Associated Blood Stream Infections (CLABSI) care bundle b) Ventilator Associated pneumonia (VAP) care bundle c) Infection Control Policy d) Baby Friendly Hospital Initiative e) Milk Supply/Preparation There is a mechanism for and evidence of a periodic review at least once in every three years. Note: <i>Standard policies and procedures, manuals etc. developed and issued by Central Bodies and/or Ministry of Health and other related Regulatory Bodies shall act as a point of reference if direct adoption are not relevant to the level of services.</i>				
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for the Paediatric and Neonatal Critical Care Services include but not limited to as listed in (a) to(e).			
		2. Policies and procedures are consistent with regulatory requirements and current standard practices such as Paediatric Services Operational Policy 2012 MOH/P/PAK/175.08 (BP) Paediatric Protocol (latest edition) , Private Healthcare Facilities and Services Act 1998 (PHFSA), its Regulation (2006), Ministry of Health Guidelines, Centers for Disease Control and Prevention (CDC)			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS				
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING			
		regulations and guidelines etc.							
		3. Policies and procedures are updated, endorsed and dated; and where required customised to meet the relevant needs and level of services of the facilities.							
		4. Policies and procedures governing patient nutrition and hygiene (including housekeeping, linen and patients' unit hygiene) are available.							
		5. Policies and procedures of each unit are appropriate to the Facility's scope of Paediatric and Neonatal Critical Care Services.							
		6. Evidence of periodic review of policies and procedures.							
		7. The policies and procedures are endorsed and dated.							
	Facility Comments:								
13A.3.1.2	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved. Cross departmental collaboration is practised in developing relevant policies and procedures where applicable. These policies and procedures are consistent with current international standards for critical care services.								
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.							
		2. Minutes of meeting with evidence of cross reference with other departments							
		3. Documented cross departmental policies							
		4. Attendance list of the stakeholders in the meeting or committee							
	Facility Comments:								

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
13A.3.1.3 CORE	A policy and procedure manual is kept up to date and is readily accessible to all staff and medical practitioners. There is EVIDENCE OF COMPLIANCE with the policy and procedure manual. The manual shall include among others policies for the following: a) functions and authority of the unit managers with special emphasis on the working relationships that exist among the attending medical practitioners, the unit manager and/or other specialist paediatric critical care unit medical practitioners; b) specifications as to who may perform special procedures, under what circumstances and under what degree of supervision; special procedures in this context may include intubation, tracheostomy, insertion of central lines, or any other invasive procedures; other procedures that include all forms of medical intervention like ventilation, dialysis and other forms of life support; c) admission, discharge and referral; d) the use of special equipment and supplies and where they are located; e) the assignment of responsibility for preventive and corrective maintenance programme, including procedures to follow in the event of the breakdown of essential equipment; f) prevention and control of infection, including needle stick injury; g) clinical management protocols, e.g. enteral feeding, thromboprophylaxis, Therapeutic Hypothermic Protocol etc; h) drug administration including antibiotic usage; i) procedural policy, e.g. central vein catheterisation; j) visitors and traffic control; k) organ donation; l) withdrawal and withholding of life support for the critically ill; m) mechanical ventilation (if absolutely necessary) outside Intensive Care Unit.					
	EVIDENCE OF COMPLIANCE				1. Policy and procedure manual (hard or soft copies) that shall include but not limited to (a) to (m).	
					2. Verification of staff compliance to practice upon observation on-site eg. Hand Hygiene Audit	
					3. Review of patient notes regarding drug administration eg. usage of antibiotics, thromboprophylaxis	

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		4. Result of audits on compliance to policies and procedures, e.g. medication safety audit, care of intravenous (IV) line, etc.				
		5. Records on hand washing audits, Central Line Associated Blood Stream Infections (CLABSI) rates, nosocomial infection rates and mortality rates				
		6. Presence of Therapeutic Hypothermic Protocol				
		7. Records on screening programmes eg. Critical Congenital Heart Disease Screening, Congenital Hypothyroid Screening, Universal Newborn Hearing Screening and Retinopathy of Prematurity Screening				
		8. Medical Alert System eg. Code Blue system				
		9. Policy on Baby Friendly Hospital Initiative				
		Facility Comments:				
13A.3.1.4 CORE	There is evidence of compliance with policies and regulations.					
	EVIDENCE OF COMPLIANCE	1. Compliance with evidence based guidelines through (at least 2 of the following methods below) :				
		a) interview of staff on practices;				
		b) verify with observation on practices;				
		c) results of audit on practices;				
		d) practices in line with established policies and procedures.				
		Facility Comments:				
13A.3.1.5	Current policies and procedures are communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/				
		2. Circulation list and acknowledgement of staff that have read the policies				
		3. Attendance list/ Minutes of meeting				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	Facility Comments:				
13A.3.1.6	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.				
	EVIDENCE OF COMPLIANCE	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.			
	Facility Comments:				
13A.3.1.7	Each discrete service has: a) a Head of service with overall responsibility; b) medical practitioners with appropriate training in intensive care (NICU/PICU) monitoring and therapy; c) specialist medical coverage available at all times; d) provision of resident medical coverage of duties on a 24-hour basis; e) resident medical practitioners with access to consultant support at all times; f) a nurse manager with an accredited post basic intensive care training, Neonatal/Paediatric Nursing qualification and experience, and nursing staff with intensive care qualifications; g) the expectation of staffing at a registered nurse to patient ratio appropriate to patient dependency needs; h) a team approach to patient care (critical care team comprises of medical and nursing staff, pharmacist, physiotherapist, dietitian and social worker); support for postgraduate education for clinical staff. i) support for postgraduate education for clinical staff.				
	EVIDENCE OF COMPLIANCE	1. The NICU and PICU Units should have one Consultant (Neonatologist/ Paediatrician) who is responsible for the direction and management of the Unit.			
		2. Call roster for medical officers, specialists and/or consultants; dated, signed and authorised by Head of Unit.			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	3.	Call roster for nurse manager on daily and on-call roster			
	4.	Nursing staff to patient ratio, please refer to 13A.2.1.3			
	a)	At no time should a critical care patient be left unattended			
	b)	Nursing Staff who support NICU/PICU must have training appropriate to their role in the care of sick paediatric patients and support for their parents.			
	5.	Other team members include (but not limited to) :			
	a)	radiographers;			
	b)	pharmacists;			
	c)	physiotherapists;			
	d)	neurophysiology staff;			
	e)	dietitians;			
	f)	infection control staff;			
	g)	social welfare workers.			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT						
<u>TOPIC 13A.4:</u>	<u>FACILITIES AND EQUIPMENT</u>					
<u>STANDARD</u> <u>13A.4.1</u>	<i>There are appropriate and adequate physical facilities and equipment for the efficient operations of the Paediatric Critical Care Services-SCN/NICU/PICU/PHDW</i>					
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
13A.4.1.1	The Paediatric Critical Care Services shall be provided in a discrete area close to areas which have the greatest requirements for its services such as operating theatres etc.					
	EVIDENCE OF COMPLIANCE	1. The Paediatric and Neonatal Critical Care Services should be situated in a discrete area with easy access to operating theatres, Emergency Department, Radiology/Diagnostic Imaging Services, etc.				
		2. The unit should be easily accessible with clear signage.				
		Facility Comments:				
13A.4.1.2 CORE	There are adequate and appropriate facilities and equipment with proper utilisation of space to enable staff to carry out their professional, teaching and administrative functions.					
	EVIDENCE OF COMPLIANCE	1. Adequate and proper utilisation of space.				
		2. Appropriate type of equipment to match the complexity of services.				
		3. Adequate facilities and equipment at each patient care area for safe care. (e.g. ventilator, defibrillators, emergency cart, hand washing facilities etc)				
		4. Easy access and clear exit routes				
		5. Absence of overcrowding				
		6. Accessibility of critical equipment and consumables at all times.				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	Facility Comments:				
13A.4.1.3	The immediate physical environment of the patient is as unobtrusive and as aesthetically pleasing as possible.				
	EVIDENCE OF COMPLIANCE	1. Physical environment of the patient is unobtrusive upon observation on-site.			
	Facility Comments:				
13A.4.1.4 CORE	There shall be adequate facilities for infection control in the unit such as: a) sinks with elbow/foot operated faucets; b) hand-drying facility, e.g. disposable paper towels; c) alcohol-based hand rub per bed; d) separate clean and dirty utility rooms; e) endotracheal suctioning via a closed system or a single use disposable catheter. Refer to Policies & Procedures on Infection Prevention and Control 2019 3 rd edition Ministry of Health Malaysia				
	EVIDENCE OF COMPLIANCE	1. Infection control facilities in each unit include items (a) to (e) as observed on site.			
	Facility Comments:				
13A.4.1.5	There shall be provision for isolation of certain categories of patients, e.g. those with airborne infectious diseases.				
	EVIDENCE OF COMPLIANCE	1. Isolation rooms or areas appropriate to the level of care provided are available eg negative pressure isolation room			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		2. Area to cohort infected patients or contacts are made available if no designated rooms are provided.				
	Facility Comments:					
13A.4.1.6	There are separate areas for the sanitation and storage of equipment.					
	EVIDENCE OF COMPLIANCE	1. Separate areas for sanitation and storage of equipment observed upon site inspection such as:				
		a) clean utility/holding area(s) for storage of equipment used in the care of critical care patients;				
		b) cleaning utility/holding room for storing used and contaminated material before its removal from the care area.				
	Facility Comments:					
13A.4.1.7	There are facilities for patients, relatives and staff which include:					
	a) counselling room for parents or relatives;					
	b) rest room for staff;					
	c) changing rooms at relevant care areas where appropriate;					
	d) room for distressed parents or relatives;					
	e) waiting area for parents or relatives.					
	EVIDENCE OF COMPLIANCE	1. Presence of facilities for parents or relatives and staff include (a) to (e) as observed on site.				
	Facility Comments:					
13A.4.1.8 CORE	Whatever the design or purpose of the unit, adequate space is provided around each bed to make it easily accessible for routine and emergency care of the patient, and also to accommodate bulky equipment which may be needed and comply with the relevant regulatory requirements.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. There is adequate space around each bed for routine and emergency care that meets regulatory requirements.				
	Facility Comments:					
13A.4.1.9 CORE	The Paediatric and Neonatal Critical Care Services shall have 24-hour access to on-site laboratory services such as: a) point of care testing, e.g. blood gas, glucose, etc b) laboratory test results are available within a reasonable time frame for review and action; c) culture results are available 24 hours per day.					
	EVIDENCE OF COMPLIANCE	1. Blood gas machine is available and functional in the unit.				
		2. Records on maintenance of blood gas machine				
		3. Quality control of blood gas machine				
		4. Laboratory results are reviewed, signed (for hospitals without HIS) and plan of action documented				
		5. Interview of staff regarding availability of culture results 24 hours per day.				
		6. Laboratory Turnaround Time for Critical Care Services is the same throughout the 24 hours.				
	Facility Comments:					
13A.4.1.10 CORE	The Paediatric and Neonatal Critical Care Services shall have 24-hour access to Radiology/Diagnostic Imaging Services and blood bank services.					
	EVIDENCE OF COMPLIANCE	1. Evidence from interview of staff/records on availability of 24-hour access to radiology/diagnostic imaging services and blood bank services				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
13A.4.1.11	The Paediatric and Neonatal Critical Care Services shall have support from all surgical, medical, allied health, and diagnostic specialties, together with appropriate clerical, scientific, and other support staff.					
	EVIDENCE OF COMPLIANCE	1. Documented referral signed and dated to respective units				
		2. Response to the referral according to case-case basis				
		3. Documented reply signed and dated by respective units				
		4. Evidence of cross departmental referral where required as seen in patient's medical records.				
	Facility Comments:					
13A.4.1.12 CORE	a) Each intensive care beds should have these equipment and facilities in place according to the norms (refer Paediatric Services Operational Policy 2012 MOH/P/PAK/175.08 (BP))					
	EVIDENCE OF COMPLIANCE	1. Adequate mechanical requirements at each paediatric or neonatal bed (Level 3 or 4), such as electrical, gas outlets and suction facilities should be made available to ensure safety, easy access and maintenance, which include as listed in (a) to (k).				
		2. There should be a mixture of emergency and normal power for all electrical outlets per current regulatory requirement.				
		3. Availability of ambubags / T-piece resuscitators at each intensive neonatal bed				
	Facility Comments:					
13A.4.1.13 CORE	The beds are readily adjustable to various therapeutic positions, easily moved for transport, with locking mechanisms for a secure stationary position, cot sides, and removable headboard.					
	EVIDENCE OF COMPLIANCE	1. All the beds are functional as per standard requirement.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
13A.4.1.14 CORE	The equipment for monitoring as well as intervention shall be appropriate to the scope of services provided by the unit. (Based on Paediatric Services Operational Policy, Ministry of Health Malaysia 2012)				
	EVIDENCE OF COMPLIANCE	1. All above listed facilities and equipment for the specified level of care for Paediatric and Neonatal Critical Care Services provided are available and functional.			
	Facility Comments:				
13A.4.1.15 CORE	Facilities and equipment are appropriate to the Paediatric and Neonatal Critical Care Services which comply to relevant standards and regulatory requirements and shall include the following: a) uninterrupted power supply; b) appropriate air conditioning and/or specialised airflow patterns which comply with regulatory requirements; c) an alarm system for Paediatric and Neonatal Critical Care Services personnel to summon additional staff in an emergency; d) variable lighting systems provide at least a day and night mode; e) alternate emergency lighting, gas and power sources or other appropriate mechanisms available to operate all life support systems including suction apparatus; f) adequate supplies of medications and intravenous fluids available 24 hours a day. Refer to Paediatric Services Operational Policy 2012 MOH/P/PAK/175.08 (BP)				
	EVIDENCE OF COMPLIANCE	1. All facilities and equipment are available and functional and include systems and facilities as listed in (a) to (f).			
		2. Indenting of medication and intravenous drips according to First In First Out (FIFO) system and imprest floor stock			
		3. Back-up generator available in case of power disruption			
		4. Temperature for the medication refrigerator is kept between 2°C – 8°C with logbook of daily temperatures			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
13A.4.1.16 CORE	All other emergency and life support equipment are readily accessible and functional.				
	EVIDENCE OF COMPLIANCE	1. Emergency and life support equipment are available and functional as required:			
		a) emergency trolley;			
		b) basic resuscitation items with suction available at each patient care area as observed upon inspection e.g. Ambubag / T-piece resuscitator available by each intensive bed			
	Facility Comments:				
13A.4.1.17	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.				
	EVIDENCE OF COMPLIANCE	1. Testing, commissioning and calibration records (certificates or stickers)			
		2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as EVIDENCE OF COMPLIANCE to the relevant standards and Acts.			
	Facility Comments:				
13A.4.1.18	Expert advice concerning the safe use of, and maintenance for all biomedical devices and electrical installations are readily available at all times. Documentation of safety testing is provided on a regular basis to the unit head.				
	EVIDENCE OF COMPLIANCE	1. Training record of staff whenever there is any new medical equipment/device in the unit			
		2. Record on quality control of devices/equipment according to requirements/ policies			
		3. Contact number of technical expert of equipment/device should be made available.			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
13A.4.1.19 CORE	There is evidence that the facilities and equipment have a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.				
	EVIDENCE OF COMPLIANCE	1. Planned Preventive Maintenance records such as schedule, stickers, etc.			
		2. Planned Replacement Programme where applicable			
		3. Complaint records			
		4. Asset inventory			
	Facility Comments:				
13A.4.1.20 CORE	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.				
	EVIDENCE OF COMPLIANCE	1. User training records			
		2. Competency assessment record			
		3. Letter of authorisation			
		4. List of staff trained and competent to operate specialised equipment			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT					
<u>TOPIC 13A.5:</u>		<u>SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES</u>			
<u>STANDARD 13A.5.1</u>		<i>The Head of Paediatric Critical Care Services shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Paediatric Critical Care Services.</i>			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
13A.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Paediatric and Neonatal Critical Care Services. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.				
	EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to (f)			
		2. Records on performance improvement activities.			
		3. Minutes of performance improvement meetings			
		4. Performance improvement studies			
		5. Mortality and morbidity audits with remedial actions.			
		6. Records on innovation if available			
	Facility Comments:				
13A.5.1.2	The Head of Paediatric or Neonatal Critical Care Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement to appropriate individual/personnel within the respective services.				
	EVIDENCE OF COMPLIANCE	1. Minutes of meetings			
		2. Letter of assignment of responsibilities			
		3. Job description			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	Facility Comments:				
13A.5.1.3	The Head of Paediatric or Neonatal Critical Care Services shall ensure that the staff are adequately trained in performance improvement activities eg. Key Performance Indicators, Incident Reporting and International Organisation for Standardization (ISO)				
	EVIDENCE OF COMPLIANCE	1. System for performance activities is in place, which include:			
		a) Training of staff			
		b) Policy on the performance activity			
		c) Methodology			
		d) Register/records of incidents or shortfalls			
		2. Corrective and preventive action plans			
		3. Remedial measure			
		4. Minutes of meetings			
		5. Acknowledgment by Head of Service and PIC/Hospital Director			
		6. Feedback given to staff regarding incident reporting./ shortfalls			
	Facility Comments:				
13A.5.1.4	It is important that newborn patients have distinct methods of identification to prevent misidentification as well as to improve the quality and safety for newborns during their hospital stay following delivery. (Refer to Pekeliling Ketua Pengarah Kesihatan Bil 1/2007 MOH/P/PAK/133.07(GU) Garispanduan Sistem Kawalan Keselamatan Bayi di Hospital-Hospital Kementerian Kesihatan Malaysia)				
	EVIDENCE OF COMPLIANCE	1. Name tags of the neonate should have at least 2 identifiers – Mother's full name and Hospital RN (Registered Number) or IC			
		2. Process of discharging baby from the ward at exit points eg. guard's counter following guidelines			
		3. Identification banding at 1 body-site is compulsory but it is encouraged for 2 body sites			

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS								
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING							
	Facility Comments:										
13A.5.1.5	The Paediatric Critical Care Services has Clinical Risk Management Programme that provides an appropriate peer group structure for performing the safety and performance improvement activities to accomplish clinical care evaluation. a) The medical practitioners undertake clinical reviews of all risk assessments, incident reports, audits and safety and performance improvement activities: i) in multidisciplinary committees within the Services; ii) in a variety of purpose-specific committees, such as mortality and morbidity, blood transfusion and infection control. b) Whatever structure is utilised, provision is made for review and analysis of the clinical work of each individual clinical service, unit or function.										
	<table><tr><td rowspan="3">EVIDENCE OF COMPLIANCE</td><td>1. Risk Management Programme</td><td></td></tr><tr><td>2. Minutes of meetings</td><td></td></tr><tr><td>3. Relevant reports and documents, e.g. clinical audit reports, incident reports, mortality and morbidity review reports, etc.</td><td></td></tr></table>	EVIDENCE OF COMPLIANCE	1. Risk Management Programme		2. Minutes of meetings		3. Relevant reports and documents, e.g. clinical audit reports, incident reports, mortality and morbidity review reports, etc.				
EVIDENCE OF COMPLIANCE	1. Risk Management Programme										
	2. Minutes of meetings										
	3. Relevant reports and documents, e.g. clinical audit reports, incident reports, mortality and morbidity review reports, etc.										
	Facility Comments:										
13A.5.1.5 CORE	There is tracking and trending of specific performance indicators depending on the Unit/ Facility , not limited to but at least two (2) of the following: a) rate of central line associated blood stream infection (CLABSI) Refer to Central Venous Catheter Care Bundle Manual A quality initiative for the prevention of Central Venous Catheter-Related Blood Stream Infection (CVC-BSI) April 2008 b) rate of ventilator-associated pneumonia (VAP) For a & b , please refer attachment Paediatric and Neonatal specific Performance Indicators c) percentage of survival of inborn very low birth weight infants between 1000 – 1499g birthweight (Target: 90%) d) Refer Technical Specifications for Key performance indicators (KPI) Clinical Services Medical Programme 2019										

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	e) Report of mortality/morbidity audits/meetings being conducted in the unit with documentation of cases discussed				
	EVIDENCE OF COMPLIANCE				
	1. Specific performance indicators monitored.				
	2. Records on tracking and trending analysis.				
	3. Remedial measures taken where appropriate				
	Facility Comments:				
13A.5.1.6	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.				
	EVIDENCE OF COMPLIANCE				
	1. Results on safety and performance improvement activities are accessible to staff.				
	2. Evidence of feedback via communication on results of performance improvement activities through continuing medical education/meetings.				
	3. Minutes of service/unit/committee meetings and attendance lists				
	Facility Comments:				
13A.5.1.7	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.				
	EVIDENCE OF COMPLIANCE				
	1. Documentation on performance improvement activities and performance indicators.				
	2. Policy statement on anonymity on patients and providers involved in performance improvement activities.				
	Facility Comments:				
13A 5.1.8	Organisations should develop, review and test a disaster recovery plan. The disaster could be natural (e.g. floods, earthquakes, hurricanes, disease outbreaks), or manmade (e.g. urban fires, industrial accidents, bioterrorism).				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	EVIDENCE OF COMPLIANCE	1. Documentation on training of emergency or contingency plan						
		2. Attendance list						
		3. Evidence of practice drills e.g. fire drills						
		4. Scheduling of drills in the organization's annual plan						
	Facility Comments:							
13A 5.1.9	Validation process eg audits for performance improvement activities shall be conducted by the first and second parties. First party audit shall be performed within the organization Second party audit is by an external party validating the processes of the organization							
	EVIDENCE OF COMPLIANCE	1. Reports of first and second party audits being carried out a) Example of First party audits e.g. internal audit for KPI or ISO being carried out: i. Reports on organization performance e.g. KPI ii. Reports on compliance or conformance of the organization e.g. Incident reports iii. Documentation of any remedial measures being carried out iv. Corrective and preventive action plans in place v. Acknowledgement of Head of the Facility regarding the first party audit results and actions taken						
		b) Second Party Audit is by a certified external organization to ensure the organization' compliance						

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		and conformance eg. SIRIM for ISO, Ministry of Health for KPI				
	Facility Comments:					

SERVICE SUMMARY	
SURVEYOR SUMMARY:	
OVERALL RATING:	
OVERALL RISK:	

SURVEY ITEM & SELF-ASSESSMENT	
SERVICE STANDARD 14 : RADIOLOGY SERVICES	
	PREAMBLE <i>Radiology is a branch of medicine that uses imaging technology to screen, diagnose, and management of diseases. Radiology services comprises of, diagnostic and interventional radiology. Medical practitioners who specialise in radiology are called radiologists. Diagnostic radiology examinations include:</i> • General Radiography • Ultrasound • Computed Tomography (CT)Fluoroscopy/Angiography, Magnetic Resonance Imaging (MRI) • Mammography • Bone Mineral Densitometry (BMD) <u>Interventional Radiology</u> <i>Interventional radiology (IR) is a medical subspecialty of radiology utilising minimally invasive image guided procedure to diagnose and treat diseases in nearly every organ system. IR procedures have become an integral part of medical care and supplanted many major surgical procedures.</i> <i>Some of the examples of interventional radiology procedures include:</i> • Needle biopsies e.g liver, lung, bone, and thyroid gland. • Venous sampling e.g adrenal and petrosal sinus • Drainage procedures e.g Nephrostomy/PTBD • Vascular access procedures e.g. PICC/Chemoport /IJC insertion • Embolization to control bleeding and devascularise tumor/ abnormal vessels e.g trauma haemorrhage, Uterine artery embolization /AVM/Aneurysm • Unblock the blockage vessels e.g. Stroke thrombectomy/Vasculoplasty/stenting • Ablation therapy • Cancer treatments e.g TACE/SIRT

SURVEY ITEM & SELF-ASSESSMENT							
TOPIC 14.1:		ORGANISATION AND MANAGEMENT					
STANDARD 14.1.1		STANDARD 14.1.1: <i>The Radiology Services shall provide safe and efficient radiological services. The services shall be coordinated with other departments and services of the Facility.</i>					
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
14.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Radiology Services are clearly documented and measurable that indicates safety, quality and patient centred care. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.						
	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.					
		2. Goals and objectives of the Radiology Services in line with the Facility statements are available, endorsed and dated.					
		3. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)					
		4. Achievement of goals and objectives are monitored, reviewed and revised accordingly.					
	Facility Comments:						
14.1.1.2 CORE	There is an organisation chart which: a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head and staff of the Radiology Services; b) is accessible to all staff and clients; c) includes off-site services if applicable; d) is revised when there is a major change in any of the following:						

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS				
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING			
	i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns; category and distribution							
	EVIDENCE OF COMPLIANCE	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head and staff of the Radiology Services.						
		2. Organisation chart of the service is endorsed, dated and accessible.						
		3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).						
	Facility Comments:							
14.1.1.3	Regular staff meetings, which include medical practitioners are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Radiology Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.				3			
	EVIDENCE OF COMPLIANCE	1. Minutes are accessible, disseminated and acknowledged by the staff.						
		2. Attendance list of members with adequate representatives of the service.						
		3. Frequency of meetings as scheduled.						
		4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).						
	Facility Comments:							

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
14.1.1.4	The Radiology Services staff participate in the following:				
	a) where applicable, the clinical aspects of patient care and other radiological matters in the Facility;				
	b) Communications with the relevant services and participation in education programmes organised by the Facility, interdepartmental meetings/committees, and education programmes organised by external bodies.				
	EVIDENCE OF COMPLIANCE	1. Attendance in department/Facility-wide mortality and morbidity meetings or conferences			
		2. Participation in interdepartmental clinical radiological discussion/conference and multidisciplinary meetings.			
		3. Department/Facility-wide Continuing Medical Education (CME) programme.			
		4. Attendance in conferences and courses organised by professional bodies.			
Facility Comments:					
14.1.1.5	The Head of Radiology Services is involved in the planning, justification and management of budget and resource utilisation of the services.				
	The Head of the Service could be the Person In Charge (PIC) of the Facility in the event where there is no resident radiologist in the Facility. Where there is no resident radiologist, the following shall be applicable: i) In the case of government facilities, the services shall be overseen and supervised by the state radiologist or the assignee. ii) In the case of private facilities, the services shall have access and suitable arrangement with an off-site radiologist who shall provide interpretation of the findings of procedures, guidance, and support with regards to the safety, standardisation of procedures and equipment in addition to providing supervision for staff competency and privileges.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes of Facility-wide management meeting				
		2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service.				
		3. Approved budget and resources.				
	Facility Comments:					
14.1.1.6	The Head of Radiology Services is involved in the appointment and/or assignment of staff.					
	EVIDENCE OF COMPLIANCE	1. Records on staff interview (if applicable)				
		2. Appointment/assignment letter of Head of Service				
		3. Job description of Head of Service				
		4. Records on staff deployment				
		5. Duty roster				
	Facility Comments:					
14.1.1.7	Appropriate statistics and records shall be maintained in relation to the provision of Radiology Services and used for managing the services and patient care purposes.					
	EVIDENCE OF COMPLIANCE	1. Records are available but not limited to the following:				
		a) workload/census;				
		b) annual report;				
		c) accident/incident reports;				
		d) staffing number and staff profile;				
		e) staff training records;				
		f) data on performance improvement activities, including performance indicators.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT							
TOPIC 14.2:		<u>HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT</u>					
STANDARD <u>14.2.1</u>		<i>The Radiology Services shall be directed by a qualified radiologist and assisted by qualified support staff to achieve the services' goals and objectives; and there is a continuing education programme to enhance human resource development.</i>					
		CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
14.2.1.1 CORE	The Head and staff of the Radiology Services shall be individuals qualified by education, training, experience and certification to commensurate with the requirements of the various positions.						
	EVIDENCE OF COMPLIANCE	1. Records on credentials of Head of Service and staff required to fill up the posts within the service (to match the complexity of the Facility and services) and certification/registration.					
		2. Appointment/assignment letters					
		3. Certification					
		4. Training and competency records					
		5. Credentialing and Privileging					
		6. Valid professional Annual Practising Certificate (APC) where relevant.					
		7. Practising radiologist registered with National Specialist Register (NSR).					
	Facility Comments:						
14.2.1.2	The authority, responsibilities and accountabilities of the Head of Radiology Services are clearly delineated and documented.						
	EVIDENCE OF COMPLIANCE	1. Appointment/assignment letter for Head of Service.					
		2. Description of duties and responsibilities					
	Facility Comments:						

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
14.2.1.3	Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the need of the services.					
	EVIDENCE OF COMPLIANCE	1. Number of staff and qualification should commensurate with workload.				
		2. Staffing pattern; category and distribution				
		3. Duty roster				
		4. Census and statistics				
	Facility Comments:					
14.2.1.4	There are written and dated specific job descriptions for all categories of staff that include: a) qualifications, training, experience and certification required for the position; b) lines of authority; c) accountabilities, functions and responsibilities, d) reviewed when required and when there is a major change in any of the following: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations. e) administrative and clinical functions.					
	EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e).				
		2. Job description includes specialisation skills				
		3. Relevant privileges granted where applicable				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	4. The job description is acknowledged by the staff and signed by the Head of Service and dated.				
	Facility Comments:				
14.2.1.5	Personnel records on training, staff development, leave and others are maintained for every staff. Note: <i>Staff personal record may be kept in Human Resource Department as per Facility policy.</i>				
	EVIDENCE OF COMPLIANCE	1. Staff personal records include:			
		a) staff biodata;			
		b) qualification and experience;			
		c) evidence of current registration;			
		d) training record;			
		e) competency record and privileging;			
		f) leave record;			
		g) confidentiality agreement.			
	Facility Comments:				
14.2.1.6	All radiographic procedures shall be carried out by appropriately qualified, competent and privileged personnel				
	EVIDENCE OF COMPLIANCE	1. Qualified radiographer to carry out radiographic procedures.			
		2. Credentialing and privileging processes are in place.			
		3. Documented evidence on conferment of privileging rights (with valid period).			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
14.2.1.7	A radiologist and radiographer shall be on duty or be available on call after normal working hours.					
	EVIDENCE OF COMPLIANCE	1. Duty roster of the department/service				
		2. On-call roster				
	Facility Comments:					
14.2.1.8	There is structured orientation programme for all newly appointed staff to the Radiology Services including medical practitioners and for those new to specific areas that include the following:					
	a) explanation of the goals, objectives, policies and procedures of the Facility and those of the Radiology Services;					
	b) lines of authority and areas of responsibility;					
	c) explanation of particular duties and functions;					
	d) explanation of the methods of assigning clinical care and the standards of clinical practice;					
	e) hand over communication;					
	f) processes for resolving practice dilemmas;					
g) information about safety procedures;						
h) training in basic/advanced life support techniques;						
i) methods of obtaining appropriate resource materials;						
j) staff appraisal procedures for the Radiology Services;						
k) education on Patient and Family Rights;						
l) education on MSQH Standards requirements.						
EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme.					
	2. There is Radiology Services orientation programme with relevant topics not limited to topics covered from (a) to (l).					
	3. Attendance list					
Facility Comments:						

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS			
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
14.2.1.9	There is evidence of training needs assessment and staff development plan which provides the knowledge and skills required for staff to maintain competency in their current positions and future advancement.						
	EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and gaps identified.					
		2. A staff development plan based on training needs assessment is available.					
		3. Training schedule/calendar is in place.					
		4. Training module					
	Facility Comments:						
14.2.1.10	There are continuing education activities for staff including medical practitioners to pursue professional interests and to prepare for current and future changes in practice.						
	EVIDENCE OF COMPLIANCE	1. Contents of training programme					
		2. Training records on continuing education activities are kept and maintained for each staff.					
		3. Certificate of attendance/diploma/degree					
	Facility Comments:						
14.2.1.11	Staff including medical practitioners receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.						
	EVIDENCE OF COMPLIANCE	1. Performance appraisals for staff including medical practitioners are completed upon probationary period and as an annual exercise.					
		Facility Comments:					
14.2.1.12	In a teaching hospital, the Radiology Services shall provide educational needs and teaching for undergraduates and postgraduates without compromising patient safety						

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	and comfort.				
	EVIDENCE OF COMPLIANCE	1. Records on training provided to undergraduate and postgraduate students			
	Facility Comments:				
14.2.1.13	In Facilities which have teaching and research responsibilities, the staffs of the Radiology Services give their cooperation or participate in the teaching and research programmes.				
	EVIDENCE OF COMPLIANCE	1. Records on participation or cooperation in teaching and research programme			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 14.3:		POLICIES AND PROCEDURES				
STANDARD 14.3.1		There are written and dated policies and procedures for all activities of the Radiology Services. These policies and procedures reflect current standards of radiology/ ~~diagnostic imaging~~ practices, relevant regulations, statutory requirements and the purposes of the services. ~~There should be available~~ Throughout the Facility, a list of procedures requiring informed consent specific to radiology/ ~~diagnostic imaging~~ procedures should be available. Possible risks and complications arising from procedures should be documented either in specific consent forms or in patient's medical record.				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
14.3.1.1 CORE	There are written policies and procedures for the Radiology Services, which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated. There is a mechanism for and evidence of a periodic review at least once in every three years.					
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for the service.				
		2. Policies and procedures are consistent with regulatory requirements and current standard practices.				
		3. Evidence of periodic review of policies and procedures.				
		4. The policies and procedures are endorsed and dated.				
	Facility Comments:					
14.3.1.2	The policies and procedures shall be developed by the Radiology Services-staff in consultation with representatives from other related services.					
	EVIDENCE OF COMPLIANCE	1. Policies and procedures show evidence of cross references to relevant sources that are involved in the processes.				
		2. Minutes of meeting between relevant departments.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
14.3.1.3	Current policies and procedures are communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/ with minutes of meetings				
		2. Circulation list and acknowledgement				
	Facility Comments:					
14.3.1.4 CORE	Written policies and procedures with adequate records are maintained and shall include but not limited to the following; a) General operational policy b) Exam scheduling of patients c) Performing Radiological examinations d) Reporting, consultation, and Image management e) Safety in Radiology e.g • Radiation Safety • MR Safety • Drugs and Contrast Media safety; management of complications • Infection control • Fire Safety • Occupational Safety f) communication with referrer, nursing, and other relevant staff on matters related to the services provided. g) informed consent; h) identification of patients, correct procedure, correct site before performing the investigation; i) radiological examinations in areas other than the Radiology Department j) care of patients having special needs including those who are critically ill and those needing isolation, physically or mentally challenged patients, paediatric and geriatric patients, pregnant staff and patients, person under custody, highly infectious patients. k) Relevant procedures and safety measures for each radiological modality where necessary. l) Handling of patient's valuables.					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	m) Patients and family rights n) Contingency plan					
	EVIDENCE OF COMPLIANCE	1. Departmental policies and procedures, which include all items above				
		2. Standard anaesthetic and drug administration records are maintained, and statutory regulations relating to the control of drugs are followed.				
		3. Investigative procedures performed are documented.				
	Facility Comments:					
14.3.1.5 CORE	There is EVIDENCE OF COMPLIANCE with policies and procedures.					
	EVIDENCE OF COMPLIANCE	1. Compliance with policies and procedures through:				
		a) interview of staff on practices;				
		b) verify with observation on practices;				
		c) results of audit on practices;				
	d) verify practices in line with established policies and procedures.					
	Facility Comments:					
14.3.1.6	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws, and statutory requirements are accessible to staff.					
	EVIDENCE OF COMPLIANCE	1. Copies of related documents are accessible for staff reference.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
14.3.1.7	adiological investigation or procedure will be performed upon request by a medical practitioner or when deemed as indicated by a radiologist. Such requests will be made in writing and contain sufficient clinical information to justify the examination.					
	EVIDENCE OF COMPLIANCE	1. Policy on request for radiological investigation or procedure.				
		2. . Clinical indication/information is available on the request form/clinical order entry prior to the examination.				
	Facility Comments:					
14.3.1.8	Reports on radiological examinations are made by a radiologist. In the absence of a radiologist, the interpretation of the examination shall be made by a competent medical practitioner.					
	EVIDENCE OF COMPLIANCE	1. Reports of radiological examinations are made by a radiologist/medical practitioner under the supervision of a radiologist.				
		2. All radiological reports shall be signed and stamped by radiologist and/or medical practitioner based on the local policy.				
	Facility Comments:					
14.3.1.9	The special radiological examination excluding plain radiograph) for inpatients shall be reported within two (2) days. A copy of report shall be kept in the patient's medical record.					
	EVIDENCE OF COMPLIANCE	1. Special radiological reports are available within 2 days.				
		2. Reports of special radiological procedures are made by a radiologist.				
		3. Copy of radiological report is kept in the patient's medical record.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
14.3.1.10	The radiologist shall consult with the referring practitioner immediately when there are critical or unexpected findings. There is evidence of documentation of this consultation.					
	EVIDENCE OF COMPLIANCE	1. Documented evidence that the clinician has been informed on the critical or unexpected findings.				
	Facility Comments:					
14.3.1.11	Hard or soft copy images shall be made available for every radiological examination performed. The radiological finding/report shall be documented and be available. Where hard copies need to be stored in the Facility, these shall be stored vertically in an air-conditioned room with suitable environmental conditions to prevent fungus and in a manner for easy retrieval.					
	EVIDENCE OF COMPLIANCE	1. Policy on handing of films or soft copy images by staff or patients.				
		2. Documented evidence on films/images tracking system				
		3. Proper storage of films/Images				
	Facility Comments:					
14.3.1.12	Where the policy of the Facility allows patients to take their films home, they shall be advised to take proper care of the films and make them available whenever necessary. In Facilities where the films are not returned to patients, films may be given on loan for the purpose of obtaining a second opinion					
	EVIDENCE OF COMPLIANCE	1. Policy for allowing patient to take their films home and the documented evidence of implementation.				
		2. Policy on request for loan of films for purpose of second opinion.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
14.3.1.13	Proper documented instructions are available and safety precautions are implemented for the protection of patients and staff who are exposed to hazardous equipment. References are based on the following statutory regulations: a) Atomic Energy Licensing Act 1984 (Act 304) b) Atomic Energy Licensing Act 1984 (Act 304): Radiation Protection (Licensing) Regulations 1986 c) Atomic Energy Licensing Act 1984 (Act 304): Atomic Energy Licensing (Basic Safety Radiation Protection) Regulations 2010			
	EVIDENCE OF COMPLIANCE			
	1. Standard operating procedures for radiological safety precautions are available and implemented.			
	2. Verification on practice during survey.			
	Facility Comments:			
14.3.1.14	Staff shall ensure that patient exposure is kept as low as reasonably achievable using time, distance, shielding as well as collimation during radiological examination whilst providing images of diagnostic quality for radiological interpretation.			
	EVIDENCE OF COMPLIANCE			
	1. Documented policy on radiation protection. This is a mandate to protect patients from unnecessary radiation exposure.			
	2. Observe the practice during survey			
	Facility Comments:			
14.3.1.15	There are written procedures for: management of a) Adverse drug or contrast media reaction anaphylactic reaction. b) complication of diagnostic and therapeutic interventional procedures. There is easy access to emergency and resuscitation equipment and medical alerts.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	EVIDENCE OF COMPLIANCE	1. Documented procedures for management of adverse drug or contrast media reaction, anaphylactic reaction, or any complications during radiological procedures.						
		2. Evidence of access to/availability of emergency and resuscitation equipment and medical supplies.						
	Facility Comments:							
14.3.1.16	Guidelines for patient preparation and procedures for radiological examinations shall be available to all relevant staff.							
	EVIDENCE OF COMPLIANCE	The documented standard operational procedures and protocols for all radiological examinations must be available						
	Facility Comments:							
14.3.1.17	A technical manual for equipment shall be available within the Radiology Services.							
	EVIDENCE OF COMPLIANCE	1. Technical manual for equipment is available.						
	Facility Comments:							
14.3.1.18	There is a policy to ensure safety and confidentiality of all images.							
	EVIDENCE OF COMPLIANCE	1. verify on user access and control on all images.						
	Facility Comments:							

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
14.3.1.19 CORE	There is a Radiation Safety Committee comprising a designated Radiation Protection Officer and representatives from other services using ionising equipment.				
	a) Minutes or issues raised at the Radiation Safety Committee meetings shall be brought to the attention of the Head of clinical services and other users of radiology services.				
	b) In smaller facilities (with two or less general or dental x-ray machines), , radiation issues should be an agenda in the Safety Committee meeting.				
	EVIDENCE OF COMPLIANCE	1. Evidence of Radiation Safety Committee			
		2. Terms of Reference			
		3. Minutes of meetings, minimum of two (2) meetings per year			
		4. The committee's monitoring activities include:			
		a) radiation safety measures;			
		b) review records on staff radiation exposure;			
		c) review all recordable and reportable adverse events and incidents;			
d) plan and oversee training needs and programme on radiation protection and safety.					
Facility Comments:					
14.3.1.20	Staff involved in the operating of ionising equipment shall undergo medical examinations in accordance with Atomic Energy Licensing Act 1984 (Act 304) and Regulations on Basic Safety Radiation Protection 2010. Full medical examination and a full blood examination to be conducted by a registered medical practitioner:				
a) pre-employment medical examination;					
b) regular medical examination (at least once in three years and more frequent for those exposed to higher ionizing radiation);					
c) termination/completion of services.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Evidence of medical examination by medical practitioner including full blood count and chest x-ray as per items (a) to (c).				
	Facility Comments:					
14.3.1.21 CORE	Staff working with ionising radiation are monitored regularly. The exposure readings shall be sent to and reported by a licensed laboratory. The radiation exposure results of every staff shall be monitored by the Radiation Safety Officer.					
	For staff having exceeded the maximum permissible dose, there is a protocol for reporting, investigation, and immediate and long term remedial actions.					
	EVIDENCE OF COMPLIANCE	1. Record on individual staff radiation exposure dose.				
		2. Result on exposure reading from licensed agency/laboratory approved by Atomic Energy Licensing Board (AELB), Malaysia.				
		3. Protocol for reporting, investigation and action taken for staff having exceeded the maximum permissible dose.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT										
TOPIC 14.4:		<u>FACILITIES AND EQUIPMENT</u>								
STANDARD 14.4.1		<i>The Radiology Services shall be provided with sufficient space, suitable equipment and adequate supplies for the safe performance of all radiological services provided.</i>								
		CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS				
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT		SURVEYOR RATING		
14.4.1.1	There are adequate and appropriate facilities and equipment with proper utilisation of space to enable staff to carry out their professional, teaching and administrative functions.									
	EVIDENCE OF COMPLIANCE	1. Adequate and proper utilisation of space and equipment in compliance with relevant Act, Regulations and standards.								
		2. Appropriate type of equipment to match the complexity of services.								
		3. Adequate facilities and equipment at each patient care area for safe care. (e.g. defibrillators, emergency cart, hand washing facilities etc)								
		4. Easy access and clear exit routes								
		5. Absence of overcrowding								
	Facility Comments:									
14.4.1.2	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.									
	EVIDENCE OF COMPLIANCE	1. Certification of equipment from certified bodies, e.g. the Atomic Energy Licensing Board and Licensing Authority, Medical Device Authority (MDA) etc. as EVIDENCE OF COMPLIANCE to the relevant standards and Acts.								
		2. Testing, commissioning and calibration records (certificates or stickers)								
	Facility Comments:									

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS				
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING			
14.4.1.3 CORE	There is evidence that the facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.							
	EVIDENCE OF COMPLIANCE	1. Planned Preventive Maintenance records such as schedule, stickers, etc.						
		2. Planned Replacement Programme where applicable						
		3. Complaint records						
		4. Asset inventory						
	Facility Comments:							
14.4.1.4 CORE	Facilities and equipment shall be assessed for safety at yearly intervals by independent radiation experts (Class H license holders certified by Medical Radiation Regulatory Division Ministry of Health). Records on such assessment shall be kept.							
	EVIDENCE OF COMPLIANCE	1. Certificate from Class H license holders						
		2. Records on Quality Control report						
	Facility Comments:							
14.4.1.5	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment, e.g. Computed Tomography (CT), Magnetic Resonance Imaging (MRI), mammography, etc.							
	EVIDENCE OF COMPLIANCE	1. User training records						
		2. Competency assessment record						
		3. Evidence of privileging						
		4. List of staff trained and privileged to operate and maintain specialised equipment						
	Facility Comments:							

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
14.4.1.6 CORE	Staff working with ionising equipment shall wear appropriate monitoring devices to be assessed periodically.				
	Patients are given appropriate radiation protection during radiological examination.				
	EVIDENCE OF COMPLIANCE	1. Verification on practices for staff and patient			
		2. Documented evidence of personal radiation protective device testing and record			
	Facility Comments:				
14.4.1.7	Multilingual signs warning women of childbearing age with regards to radiation exposure and pregnancy shall be prominently displayed.				
	EVIDENCE OF COMPLIANCE	1. Availability of multilingual signs warning women of childbearing age.			
		Facility Comments:			
14.4.1.8	There shall be suitable changing rooms for patients and facilities to keep their personal valuables.				
	EVIDENCE OF COMPLIANCE	1. Changing room and facilities to keep patient's valuables.			
		Facility Comments:			
14.4.1.9	There is adequate space or area for patient preparation and observation pre and post radiological procedure.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS				
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING			
	EVIDENCE OF COMPLIANCE	1. Adequate space for patient preparation and observation pre and post radiological procedures.							
		2. Verification on practices during survey							
	Facility Comments:								
14.4.1.10	There is designated area for patient and accompanying person for ; a) breast feeding patients b) special handling/need patient e.g. Irradiated patient, psychiatric patient and person under custody. c) consultation, grievances and physical privacy								
	EVIDENCE OF COMPLIANCE	1. Ensure available space for (a) to (c)							
	Facility Comments:								

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 14.5:		<u>SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES</u>				
STANDARD <u>14.5.1</u>		<i>There are safety and performance improvement programmes to improve staff performance, clinical practices and ethical standards of the Radiology Services. There is evidence that the statistical data collected are analysed and utilised for the ongoing improvement of the Radiology Services.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
14.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Radiology Services. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.					
	EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to (f)				
		2. Records on performance improvement activities.				
		3. Minutes of performance improvement meetings				
		4. Performance improvement studies				
		5. Records on innovation if available				
	Facility Comments:					
14.5.1.2	The Head of Radiology Services has in a written document assigned responsibilities to appropriate individuals/team/committees for safety, performance improvement and risk management activities within the services.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes of meetings				
		2. Letter of assignment of responsibilities				
		3. Terms of Reference/Job description				
	Facility Comments:					
14.5.1.3	The Head of Radiology Services shall ensure that the staffs are trained and incident reports which are complete, promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility. Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.					
	EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:				
		a) Training of staff				
		b) Policy on incident reporting				
		c) Methodology of incident reporting				
		d) Register/records of incidents				
		2. Completed incident reports				
		3. Root Cause Analysis				
		4. Corrective and preventive action plans				
		5. Remedial measure				
		6. Minutes of meetings				
		7. Acknowledgment by Head of Service and PIC/Hospital Director				
		8. Feedback given to staff regarding incident reporting.				
	Facility Comments:					
14.5.1.4	The Head of Radiology Services shall ensure the provision of high quality performance through ongoing patient safety, quality improvement and risk management programmes of the Facility.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Plans for patient safety, quality improvement and risk management.				
	Facility Comments:					
14.5.1.5	There is a Clinical Risk Management Team that provides appropriate peer group structure for performing the safety and performance improvement activities to accomplish clinical care evaluation.					
	EVIDENCE OF COMPLIANCE	1. Minutes of meetings				
		2. Terms of reference of the Clinical Risk Management Team				
		3. Reports				
	Facility Comments:					
14.5.1.6	The Clinical Risk Management Team shall: a) review all clinical risk assessments, incident reports, audits, safety and performance improvement activities; b) be involved in specific multidisciplinary committees, such as Radiation Safety; Infection control, Morbidity and Mortality committee Whatever structure is utilised, provision is made for review and analysis of the clinical work of each individual unit or function of the Radiology Services.					
	EVIDENCE OF COMPLIANCE	1. Documentation of reviews of risks such as radiation hazards, Mortality and Morbidity reviews, etc.				
		2. Reports on clinical risk assessment				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS							
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING						
14.5.1.7	There is identification and stratification of risks and measures to protect the safety of patients, staff and visitors in the Radiology Services. The measures may include but not limited to: a) radiology reporting – timeliness, accuracy of reports; b) quality of examination; c) clinical information; d) complication of radiological examination; e) viewing condition; f) consent; g) communication skill; h) equipment; i) training, competency and experience <table><tr><td rowspan="3">EVIDENCE OF COMPLIANCE</td><td>1. Risk register on type of risks identified.</td><td></td></tr><tr><td>2. Stratification of risks</td><td></td></tr><tr><td>3. Measures undertaken to address identified risks to protect the safety of patients, staff and visitors.</td><td></td></tr></table> Facility Comments:	EVIDENCE OF COMPLIANCE	1. Risk register on type of risks identified.		2. Stratification of risks		3. Measures undertaken to address identified risks to protect the safety of patients, staff and visitors.			
EVIDENCE OF COMPLIANCE	1. Risk register on type of risks identified.									
	2. Stratification of risks									
	3. Measures undertaken to address identified risks to protect the safety of patients, staff and visitors.									
14.5.1.8 CORE	There is tracking and trending of specific performance indicators not limited to but at least two (2) of the following: a) <u>For Facility with Radiologist</u> i) percentage of reject/ retake of plain radiographs(Target < 5%) ii) percentage of reject / retake of mammogram images (Target < 3%) ii) percentage of radiological examination and radiographic errors, i.e. wrong marker, use of primary markers, wrong site x-rayed, wrong patient x-rayed. iii) complication rate for post-interventional procedures iv) Perfect, Good, Moderate, Inadequate (PGMI) audits for mammography (Target: ≥97% for Perfect, Good and Moderate) v) percentage of patients with significant pneumothorax/haemorrhage requiring intervention following percutaneous interventional procedures in the thorax, abdomen and pelvis									

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	(Target: ≤10%) vi) percentage of patients with waiting time of ≤60 minutes for commencement of ultrasound examination (Target: >90%) vii) turnaround time of ≤2 days for final report of special radiological examination done on inpatients (Target: ≥97%) viii) turnaround time of ≤14 days for final report of special radiological examination done on outpatients (Target: ≥90%) ix) percentage of patients developed significant contrast media extravasation following CT examination with intravenous (IV) contrast media (Target: <1%) b) For Facility without resident radiologist i) percentage of accurate interpretation of x-rays films by medical officers as reported by radiologist [in reference indicator to indicator (i)] ii) iii) percentage of reject / retake of plain radiograph; (Target <5%)percentage of radiographic errors, i.e. wrong marker, use of primary markers, wrong site x-rayed, wrong patient x-rayed				
	EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored. 2. Records on tracking and trending analysis. 3. Remedial measures taken where appropriate			
	Facility Comments:				
14.5.1.9	Feedbacks on results of safety and performance improvement activities are regularly communicated to the staff and relevant authority.				
	EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff. 2. Evidence of feedback via communication on results of performance improvement activities through direct counselling, meetings and continuing education activities.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		3. Minutes of service/committee meetings.				
	Facility Comments:					
14.5.1.10	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.					
	EVIDENCE OF COMPLIANCE	1. Documentation on performance improvement activities and performance indicators.				
		2. Policy statement on anonymity on patients and providers involved in performance improvement activities.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT				
TOPIC 14.6:	<u>SPECIAL REQUIREMENTS</u>			
STANDARD 14.6.1	<u>VIEWING SYSTEM FOR REPORTING</u> <i>The Facility shall use appropriate viewing boxes and display monitor to conduct the reporting of radiological images in satisfactory conditions.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
14.6.1.1	Viewing boxes requirements for reporting radiographs by radiologists are as follows: a) RADIOGRAPHIC VIEWING (non-mammographic) i) Radiographic illuminators: • Luminance preferably between 1500-3000 cd/m² • Uniformity of illuminator (maximum deviation < 15%) • Uniformity of colour bulbs within the department (white or moderate white-blue with flicker-free illumination) • Sufficient size for at least 2 radiographs (>40 x 80 cm) • Possibility of collimation on the size of the radiographs • Viewing box mounting shall be at an appropriate level for reviewing. ii) Special viewing possibilities: • To evaluate details in film areas of high densities (D=2-3), optimum brightness shall be of 4000-6000 cd/m² iii) Magnifying glass or lens: • magnifying factor 2-3 iv) Illumination conditions in the room: • 50 – 100 lux at the place of the viewer (with the viewer 'off') • Room lighting shall have 'dimmer switch' control (Reference: Quality Control of Radiographic Illuminators and associated viewing equipment by E Hartmann and F E Stieve, BIR Report 18, 135-7) b) MAMMOGRAPHIC VIEWING i) Luminance of viewing boxes: > 3500 cd/m² (nit) for mammography with variable illumination capability. ii) Room ambient illumination level: 50 lux or less (with viewer 'off'). iii) Collimation to size of mammographic film (Reference: ACR Guidelines)			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	c) DISPLAY MONITOR i) Viewing workstation for reporting all examinations shall be of medical grade 1-3 MP. ii) Minimum requirement of 5 MP for mammography iii)iMac as DICOM viewer is allowed for image processing. d) FREQUENCY OF TESTING FOR VIEWING BOXES AND DISPLAY MONITOR i) at commissioning; ii) after replacement of bulb or front panel of viewing box; iii) yearly for viewing box iv) 6 monthly for display/PACS monitor					
	EVIDENCE OF COMPLIANCE	1. The radiographic illuminators comply with parameters in (a)(i) to (a)(iv).				
		2. The mammographic viewer comply with (b)(i) to (b)(iii) and C) ii)				
		3. Display monitor comply with c) i-iii and d) I & iv				
		4. Evidence of testing for viewing boxes and display monitor .				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
STANDARD 14.6.2	<u>TELERADIOLOGY</u> <i>The Facility shall ensure high quality, final radiology reports and reliable, personalised teleradiology services that result in referring physician satisfaction and continually improve processes and workflows to enable the attending radiologists to provide the best patient care possible.</i>					
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
14.6.2.1	The Facility that has this service shall ensure that guidelines on telemedicine from the Ministry of Health (TELERADIOLOGY Unit) are complied with.					
	EVIDENCE OF COMPLIANCE	1. Copy of guidelines on telemedicine from the Ministry of Health (Teleradiology Unit) are available on-site.				
	Facility Comments:					
14.6.2.2	There are policies and procedures for: a) monitoring and evaluating the effective management, safety and proper performance of acquisition, digitisation, compression, transmission, archiving and retrieval functions of the system; b) patient confidentiality is maintained; c) training on the use of teleradiology equipment; d) security of software and hardware; e) timeliness of report; f) contingency plan for system failure, emergency and disaster.					
	EVIDENCE OF COMPLIANCE	1. Policies and procedures for (a) to (f) are available.				
		2. Records on training				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
STANDARD <u>14.6.3</u>	<u>ULTRASOUND</u> <i>Ultrasound Diagnostic Services shall provide a comprehensive and reliable service performed by radiologists or credentialed and privileged medical practitioners/sonographers and reported by specialists.</i>					
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
14.6.3.1	The ultrasound examination shall be performed by a radiologist/trained and privileged medical practitioner or sonographer.					
	EVIDENCE OF COMPLIANCE	1. Evidence of credentialing and privileging of staff where applicable.				
		2. Records on training				
	Facility Comments:					
14.6.3.2	All ultrasound examinations shall be interpreted and reported by a radiologist/the specialists in their area of expertise or trained and privileged medical practitioners.					
	EVIDENCE OF COMPLIANCE	1. Evidence of credentialing and privileging of medical practitioners.				
		2. Records on training				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
STANDARD 14.6.4	<u>MOBILE X-RAYS AND MOBILE C-ARM</u> <i>There are functional and safe equipment and facilities that meet the regulatory requirements for the Mobile X-Rays and Mobile C-Arm services in the Facility. The Mobile X- Rays and C-Arm shall be operated by a qualified radiographer.</i>					
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
14.6.4.1	Where Mobile X-Rays and Mobile C-Arm machines are used as static units, the facilities shall meet the requirements as per regulations for x-ray room/fluoroscopy room.					
	EVIDENCE OF COMPLIANCE	1. Certificate for static units by Class H license holder				
		2. Facilities and equipment comply with relevant Act, Regulations and standards.				
		Facility Comments:				
14.6.4.2	C-arm in the operating theatre shall be operated by a qualified radiographer.					
	EVIDENCE OF COMPLIANCE	1. Records on qualification of radiographer				
		2. Verification on practices during survey				
		Facility Comments:				
14.6.4.3	The operating theatre where fluoroscopy is constantly used shall have radiation shielding. In the other rooms where there is no radiation shielding, the radiation scatter outside the room should be monitored.					
	EVIDENCE OF COMPLIANCE	1. Facilities comply with relevant Act, Regulations and standards.				
		2. Records on monitoring on radiation scatter by the appropriately qualified personnel/agency.				
		Facility Comments:				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
14.6.4.4	When mobile x-rays are performed in the wards, efforts should be made to ensure that the neighbouring patients are protected adequately from scatter radiation.					
	EVIDENCE OF COMPLIANCE	1. Standard operating procedures for using of mobile radiography in the wards.				
		2. Verification on practices during survey				
	Facility Comments:					
14.6.4.5	The requirements on shielding and monitoring shall be applicable in other locations where fluoroscopy and mobile machines are routinely used, e.g. Intensive Care Unit (ICU), Coronary Care Unit (CCU), Coronary Rehabilitation Ward (CRW) and Emergency Services.					
	EVIDENCE OF COMPLIANCE	1. Availability of standard operating procedures for mobile radiography and fluoroscopy in other locations.				
		2. Verification on practices during survey				
	Facility Comments:					
14.6.4.6	There are guidelines on the handling, transport and storage of mobile x-ray machines and their accessories.					
	EVIDENCE OF COMPLIANCE	1. Availability of guidelines on the handling, transport and storage of mobile x-ray machines and their accessories.				
		2. Verification on practices during survey				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT	
STANDARD 14.6.5	<u>BONE DENSITOMETER</u> <i>Bone Densitometry shall only be performed in appropriate and safe facilities in accordance with the requirements of the Ministry of Health and Atomic Energy Licensing Act (Act 304) to reduce radiation exposure and optimise the diagnostic quality of the scans. Records shall be maintained for each bone densitometer unit.</i>

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
14.6.5.1	The room used for Bone Densitometer shall meet the required specifications for such facilities in accordance with the requirements of the Ministry of Health and Atomic Energy Licensing Act (Act 304).					
	EVIDENCE OF COMPLIANCE	1. Certification from Class H license holder				
		2. Facilities and equipment comply with relevant Act, Regulations and standards.				
	Facility Comments:					
14.6.5.2	Bone densitometry examination shall be performed by a qualified radiographer. The radiographer shall be adequately trained, credentialed and privileged.					
	EVIDENCE OF COMPLIANCE	1. Evidence of credentialing and privileging of the radiographer				
		2. Records on training.				
	Facility Comments:					
14.6.5.3	There is evidence that the competency of the radiographer performing the examination is assessed by performing the precision testing.					
	EVIDENCE OF COMPLIANCE	1. Documentation of competency test				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
STANDARD 14.6.6	<u>MAMMOGRAPHY</u> <i>The Facility ensures that mammography services shall be performed only by adequately trained, credentialed and privileged radiographer/mammographer as per policy of the Facility. A radiologist trained to read mammograms shall report on the mammogram images. The facilities and equipment for mammography examinations shall be safe and routine Quality Control is performed to ensure reliable results.</i>					
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
14.6.6.1	Mammography shall be performed by a qualified female radiographer. The mammographer shall be adequately trained, credentialed and privileged.					
	EVIDENCE OF COMPLIANCE	1. Evidence of credentialing and privileging of relevant staff.				
		2. Records on training				
	Facility Comments:					
14.6.6.2	All mammography shall be interpreted and reported by a radiologist. All mammography may be interpreted by the specialists in their areas of expertise.					
	EVIDENCE OF COMPLIANCE	1. Evidence of credentials of radiologist (Registration with National Specialist Register)				
		2. Sampling of mammography report.				
	Facility Comments:					
14.6.6.3	There is evidence that the mammographers and the radiologists reporting the mammogram attend regular relevant continuing medical education (CME).					
	EVIDENCE OF COMPLIANCE	1. Records on continuing medical education for relevant staff.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
14.6.6.4	The mammographer responsible for quality control (QC) is specifically trained to perform routine QC tests. The results are used to troubleshoot and for quality improvement.					
	EVIDENCE OF COMPLIANCE	1. Documentation of QC test.				
		2. Evidence of quality improvement done.				
	Facility Comments:					
14.6.6.5 CORE	The mammograms produced are audited following the Perfect, Good, Moderate and Inadequate (PGMI) classifications with evidence of documentation.					
	EVIDENCE OF COMPLIANCE	1. Documentation on PGMI audits.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
STANDARD 14.6.7	<i>MAGNETIC RESONANCE IMAGING (MRI)</i> <i>MRI shall be performed by a qualified, trained, and privileged radiographer. All MRI examinations shall be interpreted and reported by a radiologist/specialist. There are policies and procedures addressing the safety, operations and maintenance of the MRI equipment.</i>					
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
14.6.7.1	Magnetic Resonance Imaging (MRI) examination shall be performed by a qualified radiographer. The radiographer shall be adequately trained, and privileged.					
	EVIDENCE OF COMPLIANCE	1. Evidence of privileging of radiographer.				
		2. Records on training.				
	Facility Comments:					
14.6.7.2	All MRI examinations shall be interpreted and reported by a radiologist. All MRI examinations may be interpreted by the specialists in their areas of expertise.					
	EVIDENCE OF COMPLIANCE	1. Evidence of credentials of radiologist (Registration with National Specialist Register)				
		2. Sampling of MRI examination reports				
	Facility Comments:					
14.6.7.3 CORE	There are policies and procedures addressing the safety, operations and maintenance of the MRI equipment.					
	EVIDENCE OF COMPLIANCE	1. Policies and procedures for safety, operations and maintenance of the MRI equipment.				
		2. Verification on practices during survey				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		3. Check on ancillary and maintenance workers/staff on their knowledge of safety and compliance				
	Facility Comments:					
14.6.7.4	There are guidelines for the handling of the following patients: a) ambulatory; b) on wheelchair and trolley; c) requiring oxygen support; d) critically ill patients or on ventilator; e) infants and children; f) patients with implants; g) patients with special needs h) pregnant patient; i) patients with or suspected renal failure. j) infectious disease patients k) Polytrauma patients					
	EVIDENCE OF COMPLIANCE	1. Availability of guidelines for handling of patients as indicated in (a) to (k) for MRI examination.				
		2. Verification on practices during survey				
	Facility Comments:					
14.6.7.5	There shall be procedures for handling of emergencies, e.g. quenching, fire outbreak, accidents in the magnet room etc.					
	EVIDENCE OF COMPLIANCE	1. Availability of procedures on handling of clinical and non clinical emergencies.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
14.6.7.6	There shall be provision for MRI compatible patient and staff safety equipment.					
	EVIDENCE OF COMPLIANCE	1. Availability of MRI compatible equipment.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT				
STANDARD 14.6.8	<u>COMPUTED TOMOGRAPHY (CT)</u> <i>The Facility ensures that CT examinations are performed on selective patients and they are provided with current and accurate information about its benefits and risks . The staffs performing CT examination are adequately trained, and privileged. Adherence to relevant regulations and guidelines regarding safety and use of ionizing radiation are observed by the imaging personnel. The CT scan facilities and equipment are monitored regularly by a medical physicist to ensure that the equipment is functioning properly and taking optimal images.</i>			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT
				SURVEYOR RATING
14.6.8.1	Computed Tomography (CT) examination shall be performed by a qualified radiographer. The radiographer shall be adequately trained, and privileged.			
	EVIDENCE OF COMPLIANCE	1. Evidence of privileging of relevant staff.		
		2. Records on training.		
	Facility Comments:			
14.6.8.2	Imaging personnel and the facilities shall adhere to regulations and guidelines regarding the use of ionizing radiation, e.g. Atomic Energy Licensing Act (Act 304), Atomic Energy Licensing Board (AELB), and Atomic Energy Licensing (Basic Safety Radiation Protection) Regulation 2010.			
	EVIDENCE OF COMPLIANCE	1. Verification on practices during survey on adherence to relevant Regulations and guidelines.		
	Facility Comments:			
14.6.8.3	The CT scan room shall meet the required specifications for such facilities in accordance with the requirements of the Ministry of Health and Atomic Energy Licensing Act (Act 304).			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	EVIDENCE OF COMPLIANCE	1. Certification from Class H license holder						
		2. Facilities and equipment comply with relevant Act, Regulations and standards.						
	Facility Comments:							
14.6.8.4	All CT scan examinations shall be interpreted and reported by a radiologist. All CT scan examinations may be interpreted by the specialists in their areas of expertise.							
	EVIDENCE OF COMPLIANCE	1. Evidence of credentials of radiologist (Registration with National Specialist Register)						
		2. Sampling of CT scan examination reports.						
	Facility Comments:							
14.6.8.5	There are policies and procedures addressing the safety, operations and maintenance of the CT scan equipment.							
	EVIDENCE OF COMPLIANCE	1. Policies and procedures on safety, operations and maintenance of the CT scan equipment.						
		2. Verification on practices during survey on compliance with policies and procedures						
	Facility Comments:							
14.6.8.6	Documented indications and justifications are available for the use of CT scan, e.g. prolong headache, head trauma, solitary pulmonary nodule, low back pain, CT colonoscopy, CT coronary and/or other relevant conditions as deemed by the services.							
	EVIDENCE OF COMPLIANCE	1. Indications for CT scan are available and documented in patient's medical record.						
		Facility Comments:						

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
14.6.8.7	There are guidelines for the handling of the following patients: a) ambulatory; b) acute stroke c) requiring oxygen support; d) critically ill patients or on ventilator; e) infants and children; f) patients with special needs g) pregnant patient; h) patients with or suspected renal failure. i) infectious disease patients; j) Polytrauma patients			
	EVIDENCE OF COMPLIANCE	1. Guidelines for the handling of patients as indicated in (a) to (j)		
	Facility Comments:			
14.6.8.8	The imaging equipment is monitored regularly by a medical physicist to ensure that the equipment is functioning properly, taking optimal images and radiation safety is ensured.			
	EVIDENCE OF COMPLIANCE	1. Records on monitoring of CT machine by medical physicist are available. 2. Evidence of patient dose monitoring is available		
	Facility Comments:			

SURVEY ITEM & SELF-ASSESSMENT						
STANDARD 14.6.9	ANGIOGRAPHY <i>Angiography examinations shall be performed by qualified, and privileged radiologist and medical practitioner in a safe facility that meets the specifications of the Ministry of Health and Atomic Energy Licensing Act (Act 304) and its subsidiary regulations as well as adherence to regulatory requirements on the use of ionizing radiation, e.g. Atomic Energy Licensing Board (AELB), Atomic Energy Licensing (Basic Safety Radiation Protection) Regulation 2010. There are policies, procedures and guidelines to ensure patient and staff safety.</i>					
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
14.6.9.1	Angiography examinations shall be performed by privileged radiologist, assisted by radiographer and nurses.					
	EVIDENCE OF COMPLIANCE	1. Evidence of privileging of radiologist/relevant staff.				
		2. Records on training.				
	Facility Comments:					
14.6.9.2	There are specific policies and procedures that include but not limited to: a) patient identification and verification of the nature of investigation; b) informed consent; c) infection control; d) angiography diagnostic and therapeutic procedures; e) management of patient pre and post procedures; f) operations and maintenance of the angiography equipment. g) radiation safety and dose monitoring					
	EVIDENCE OF COMPLIANCE	1. Specific policies and procedures which include but not limited to items (a) to (g).				
		2. Verification on practices during survey on compliance with policies and procedures				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
14.6.9.3	Imaging personnel and the facilities for angiography shall adhere to regulations and guidelines regarding the use of ionizing radiation, e.g. Atomic Energy Licensing Act (Act 304), Atomic Energy Licensing Board (AELB), Atomic Energy Licensing (Basic Safety Radiation Protection) Regulation 2010.					
	EVIDENCE OF COMPLIANCE	1. Verification on practices during survey on compliance to relevant Regulations and guidelines.				
	Facility Comments:					
14.6.9.4	The angiography room shall meet the required specifications for such facilities in accordance with the requirements of the Ministry of Health and Atomic Energy Licensing Act (304) and its subsidiary regulations.					
	EVIDENCE OF COMPLIANCE	1. Certification from Class H license holder				
		2. Facilities and equipment comply with relevant Act, Regulations and standards.				
		3. Room to be equipped with HEPA (High Efficiency Particulate Air) filter				
	Facility Comments:					
14.6.9.5	All angiography examinations shall be interpreted and reported by privileged radiologist. All angiography examinations may be interpreted by the specialists in their areas of expertise.					
	EVIDENCE OF COMPLIANCE	1. Evidence of privileging of radiologist.				
		2. Records on training.				
		3. Sampling of angiography reports.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
14.6.9.6 CORE	There is evidence of special handling and compliance with guidelines to ensure patient and staff safety; a) critically ill patients or on ventilator; b) infants and children; c) patients with special needs d) pregnant patient; e) patients with or suspected renal failure. f) highly infectious cases; g) Polytrauma patients h) radiation safety i) handling of catheters, monitoring equipment, radiopharmaceutical agent and waste (in collaboration with nuclear medicine team) and other items. j) complication of diagnostic and therapeutic interventional radiological procedures				
	EVIDENCE OF COMPLIANCE	1. Policies and procedures on radiation safety and handling of catheters, radiopharmaceutical agent and waste(in collaboration with nuclear medicine team), monitoring equipment and other items.			
		2. Verification on practices during survey on compliance with policies and procedures			
	Facility Comments:				
14.6.9.7 CORE	Support services such as anaesthetic and critical care services, emergency and resuscitation equipment are easily accessible.				
	EVIDENCE OF COMPLIANCE	1. Evidence of access to anaesthetic and critical care services, emergency and resuscitation equipment			
		Facility Comments:			

SURVEY ITEM & SELF-ASSESSMENT						
STANDARD 14.6.10	<u>PICTURE ARCHIVING AND COMMUNICATIONS SYSTEM (PACS)</u>					
	<i>Where PACS is used, the Facility shall ensure that there are adequate provisions for the secure use, access and maintenance of the system, both within and outside the main Radiology Services/Department.</i>					
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
14.6.10.1	There shall be adequate provisions with regards to the secure use, access and maintenance of the Picture Archiving and Communications System (PACS), both within and outside the Radiology Services/Department.					
	EVIDENCE OF COMPLIANCE	1. Policies and procedures on secure use, access and maintenance of the PACS.				
		2. Verification on practices during survey				
	Facility Comments:					
14.6.10.2	There is a policy to ensure safety and confidentiality of images archived.					
	EVIDENCE OF COMPLIANCE	1. Policy on safety and confidentiality of images archived				
		2. Verification on practices during survey				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT								
STANDARD 14.6.11	DARKROOM AND FILM PROCESSORS The Head of Radiology Services should ensure safety precautions are taken to provide a safe environment within the darkroom to address safety aspects of staff and radiological films.							
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
14.6.11.1	The darkroom or area/equipment shall be equipped with an effective exhaust system and adequate ventilation.							
	EVIDENCE OF COMPLIANCE	1. Adequate exhaust and ventilation systems in the darkroom area.						
		2. Odour-free environment.						
	Facility Comments:							
14.6.11.2	The Radiology Services shall ensure safety precautions are taken to avoid accidental light exposure to films.							
	EVIDENCE OF COMPLIANCE	1. Provision for accidental light exposure such as:-						
		a) light tight single or double door;						
		b) door bell;						
		c) darkroom safe light.						
	Facility Comments:							
14.6.11.3	Existing facilities ensure safety aspects of staff.							
	EVIDENCE OF COMPLIANCE	1. Clutter-free room for safe movement of staff.						
		2. General cleanliness of the room.						
		3. Observation on safety aspects of darkroom during survey.						
	Facility Comments:							

SURVEY ITEM & SELF-ASSESSMENT						
STANDARD 14.6.12	<u>DISPOSAL OF CHEMICAL WASTE</u> <i>The Facility has proper arrangements for the storage and disposal of chemical waste as defined in the Environmental Quality Act 1974 (Act 127) and subsequent amendments and the subsidiary legislation referring to scheduled waste.</i>					
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
14.6.12.1	There are proper arrangements made for the labelling, storage and disposal of chemical waste as defined in the Environmental Quality Act 1974 (Act 127) and subsequent amendments and the subsidiary legislation and Atomic Energy Licensing Act 1984 referring to scheduled waste.					
	EVIDENCE OF COMPLIANCE	1. Standard operating procedures on storage and disposal of chemical waste.				
		2. Verification on practices during survey				
	Facility Comments:					

SERVICE SUMMARY

SURVEYOR SUMMARY:

OVERALL RATING:

OVERALL RISK:

SURVEY ITEM & SELF-ASSESSMENT				
SERVICE STANDARD 15 : PATHOLOGY SERVICES				
	<u>PREAMBLE</u> <i>Pathology Services may be provided by a laboratory or laboratories within, or external to the Facility. The Pathology Services may include Anatomical Pathology, Chemical Pathology, Haematology, Microbiology and Genetics. The services shall be organised and administered to provide a comprehensive and quality diagnostic service which is innovative, efficient and reliable for quality and safe patient care.</i>			
TOPIC 15.1:	<u>ORGANISATION AND MANAGEMENT</u>			
STANDARD 15.1.1	<i>Where Pathology Services are provided, the Pathology Services shall be organised and administered to provide quality laboratory and diagnostic services appropriate to the clinical services provided by the Facility.</i>			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT
				SURVEYOR RATING
15.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Pathology Services are clearly documented and measurable that indicates safety, quality and patient centred care. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.			
	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.		
		2. Goals and objectives of the Pathology Services in line with the Facility statements are available, endorsed and dated.		
		3. Evidence of planned reviews of the above statements.		
		4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)		

		5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.				
		Facility Comments:				
15.1.1.2 CORE		There is an organisation chart which: a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head and staff of the Pathology Services; b) includes linkage to parent company if the service is outsourced where applicable; c) is accessible to all staff and clients; d) includes off-site, satellite, cluster hospital laboratory (where applicable); e) is revised when there is a major change in any of the following: i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns. All off-site and satellite, cluster hospital laboratory under the purview of Pathology Services shall be included in the main organisation chart.				
	EVIDENCE OF COMPLIANCE	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head and staff of the Pathology Services.				
		2. Organisation chart of the service is endorsed, dated and accessible.				
		3. The organisation chart is revised when there is a major change in any of the items (e)(i) to (iv).				
		4.				
		Facility Comments:				
15.1.1.3		Regular staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Pathology Services. Minutes are kept; decisions and resolutions made during meetings shall be communicated and accessible to all staff of the service and implemented.				
	EVIDENCE OF COMPLIANCE	1. Minutes are accessible, disseminated and acknowledged by the staff.				
		2. Attendance list of members with adequate representatives of the service.				
		3. Frequency of meetings as scheduled.				

		4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).				
		Facility Comments:				
15.1.1.4		The Head of Pathology Services is involved in the planning, justification and management of the budget and resource utilisation of the services.				
	EVIDENCE OF COMPLIANCE	1. Minutes of Facility-wide management meeting				
		2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service.				
		3. Approved budget and resources.				
		Facility Comments:				
15.1.1.5		The Head of the Pathology Services is involved in the appointment and/OR assignment of staff.				
	EVIDENCE OF COMPLIANCE	1. Records on staff interview (if applicable)				
		2. Appointment/assignment letter of Head of Service				
		3. Job description of Head of Service				
		4. Records on staff deployment				
		5. Duty roster				
		Facility Comments:				
15.1.1.6		The Head of Pathology Services is responsible for the medical and technical aspects of the testing and is involved in the safety and performance improvement activities of the Facility as appropriate.				
	EVIDENCE OF COMPLIANCE	1. Credentials and job description of Head of Pathology Services.				
		Facility Comments:				

15.1.1.7	There is cooperation from the staff of Pathology Services with other relevant staff in contributing to patient care on matters related to laboratory activities and knowledge.						
	EVIDENCE OF COMPLIANCE	1. Documented evidence of interaction with the relevant staff of the facility/services.					
	Facility Comments:						
15.1.1.8	Appropriate statistics and records shall be maintained in relation to the provision of Pathology Services and used for managing the services and patient care purposes.						
	EVIDENCE OF COMPLIANCE	1. Records are available but not limited to the following:					
		a) workload/census					
		b) annual report;					
		c) accident/incident reports;					
		d) staffing number and staff profile;					
		e) staff training records;					
		f) data on performance improvement activities, including performance indicators.					
	Facility Comments:						
15.1.1.9 CORE	Where services are provided in areas other than in the main Pathology Services, for example, Intensive Care Units, neonatal nurseries, the following requirements shall be considered:						
	a) responsibility for the operations of those services is clearly defined; b) staff are closely supervised and given appropriate instructions of operations of the services by assigned staff from the main Pathology Services; c) the equipment is properly maintained and quality control is carried out and documented.						

	EVIDENCE OF COMPLIANCE	1. Define responsibility for the operations of the services outside of the main Pathology Services.				
		2. Records on training				
		3. Records on staff supervision				
		4. Records on the equipment maintenance				
		5. Records on quality control (QC) carried out				
		6. Record on monitoring by laboratory staff				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
STANDARD 15.1.2	<i>Facilities that do not have their own Pathology Services or cannot provide a full range of laboratory services, shall arrange with an external laboratory or laboratories to provide the services needed. These laboratories shall be accredited by recognised body, e.g. Standards Malaysia (MS ISO 15189). The Facility shall appoint a registered medical practitioner or designated responsible officer to monitor the services provided by the external laboratories comply with the relevant MSQH Standards of Accreditation.</i>					
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT		
15.1.2.1	The external providers of the Pathology Services shall conform to all relevant MSQH Standards of Accreditation.					
	EVIDENCE OF COMPLIANCE	1. The off-site laboratory shall be MS ISO 15189 accredited.				
		2. There is written agreement between the external service provider and the Facility.				
	Facility Comments:					
15.1.2.2 CORE	There is written agreement with the external service provider and the Facility specifying the following requirements: a) availability of a pathologist for consultation; b) provision of adequate numbers of appropriately qualified personnel to perform their duties; c) the type and nature of tests and investigation that are available; d) requests for tests/investigations shall be documented; e) effective and safe transmission of specimens; f) provision for immediate communication of results out of the normal range; g) arrangements for after-hours and emergency work; h) quality systems shall be in place, which include Internal Quality Control (IQC), External Quality Assurance (EQA), monitoring turnaround time (TAT), accreditation status.					

	EVIDENCE OF COMPLIANCE	1. There is written agreement with the external service provider and the Facility specifying items (a) to (h).				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT					
TOPIC 15.2:		<u>HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT</u>			
<u>STANDARD</u> <u>15.2.1</u>		<i>Pathology Services shall be directed and supervised by a pathologist. The day-to-day operations of the service may be delegated to a suitably qualified and experienced officer, supported by appropriately qualified staff.</i> <i>*Refer: Departmental Policy of Pathology Services in Ministry of Health, Malaysia</i>			
				SURVEYOR FINDINGS	

	EVIDENCE OF COMPLIANCE	1. Records on credentials of Head of Service and staff required to fill up the posts within the service (to match the complexity of the Facility and services) and certification/registration.				
		2. Current Annual Practising Certificate (APC)				
		3. Appointment/assignment letters				
		4. National Specialist Register (NSR) for Pathologist				
		5. Training and competency record				
	Facility Comments:					
15.2.1.3	The authority, responsibilities and accountabilities of the Head of Pathology Services are clearly delineated and documented.					
	EVIDENCE OF COMPLIANCE	1. Appointment/assignment letter for Head of Service.				
		2. Description of duties and responsibilities				
	Facility Comments:					
15.2.1.4 CORE	Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the need of the services.					
	Notes/Explanations Staff are adequately trained and qualified to perform the tasks required of them. The number of staff employed shall commensurate with the workload of the Pathology Services.					
	EVIDENCE OF COMPLIANCE	1. Number of staff and qualification should commensurate with workload.				
		2. Staffing pattern				
		3. Duty roster				
		4. Census and statistics				
	Facility Comments:					

15.2.1.5	There are written and dated specific job descriptions for all categories of staff that include: a) qualifications, training, experience and certification required for the position; b) lines of authority; c) accountability, functions and responsibilities; d) reviewed when required and when there is a major change in any of the following: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations. e) administrative and clinical functions.														
	<table><tr><td rowspan="4">EVIDENCE OF COMPLIANCE</td><td>1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e).</td><td></td></tr><tr><td>2. Job description includes specialisation skills</td><td></td></tr><tr><td>3. Relevant privileges granted where applicable</td><td></td></tr><tr><td>4. The job description is acknowledged by the staff and signed by the Head of Service and dated.</td><td></td></tr></table>	EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e).		2. Job description includes specialisation skills		3. Relevant privileges granted where applicable		4. The job description is acknowledged by the staff and signed by the Head of Service and dated.						
EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e).														
	2. Job description includes specialisation skills														
	3. Relevant privileges granted where applicable														
	4. The job description is acknowledged by the staff and signed by the Head of Service and dated.														
	Facility Comments:														
15.2.1.6	Personnel records on training, staff development, leave and others are maintained for every staff. Note: <i>Staff personal record may be kept in Human Resource Department as per Facility policy.</i>														
	<table><tr><td rowspan="5">EVIDENCE OF COMPLIANCE</td><td colspan="2">1. Staff personal records include:</td></tr><tr><td>a) staff biodata;</td><td></td></tr><tr><td>b) qualification and experience;</td><td></td></tr><tr><td>c) evidence of current registration;</td><td></td></tr><tr><td>d) training record;</td><td></td></tr></table>	EVIDENCE OF COMPLIANCE	1. Staff personal records include:		a) staff biodata;		b) qualification and experience;		c) evidence of current registration;		d) training record;				
EVIDENCE OF COMPLIANCE	1. Staff personal records include:														
	a) staff biodata;														
	b) qualification and experience;														
	c) evidence of current registration;														
	d) training record;														

		e) competency record and privileging;				
		f) leave record;				
		g) confidentiality agreement;				
		h) health screening status;				
		i) immunisation status.				
	Facility Comments:					
15.2.1.7	There is a comprehensive and structured orientation and induction programme where new staff including medical practitioners are briefed on their services, operational policies and relevant aspects of the Facility to prepare them for their roles and responsibilities. This includes but not limited to:					
	a) rules and regulations, especially those related to health hazards and safety precautions;					
	b) requirements for immunisation against certain high-risk diseases;					
	c) policies and procedures on all aspects of Pathology Services;					
	d) all relevant manuals, e.g. health and safety manual.					
	EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme.				
		2. There is Pathology Services orientation programme with relevant topics not limited to topics covered from (a) to (d).				
		3. Attendance list				
	Facility Comments:					
15.2.1.8	There is evidence of training needs assessment and staff development plan which provides the knowledge and skills required for staff to maintain competency in their current positions and future advancement.					
	EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and gaps identified.				
		2. A staff development plan based on training needs assessment is available.				
		3. Training schedule/calendar is in place.				
		4. Training module				
	Facility Comments:					

15.2.1.9	There are continuing education activities for staff to pursue professional interests and to prepare for current and future changes in practice.					
	EVIDENCE OF COMPLIANCE	1. Training calendar includes in-house/external courses/workshop/conferences				
		2. Contents of training programme				
		3. Training records on continuing education activities are kept and maintained for each staff including training in life support.				
		4. Certificate of attendance/degree/post basic training.				
	Facility Comments:					
15.2.1.10	The Pathology Services shall provide a continuing education activity for non-laboratory health professional staff to keep them informed of matters related to Pathology Services.					
	EVIDENCE OF COMPLIANCE	1. Continuing medical education for non-laboratory health professional staff.				
		2. Records on attendance				
	Facility Comments:					
15.2.1.11	Staff including medical practitioners receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.					
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff including medical practitioners are completed upon probationary period and as an annual exercise.				
		Facility Comments:				
15.2.1.12	Where applicable, the functions of the Pathology Services include undergraduate, postgraduate and other health professional education, research projects and special studies, as appropriate.					

	EVIDENCE OF COMPLIANCE	1. Memorandum of Understanding (MOU)				
		2. Records on training				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT			
TOPIC 15.3:	<u>POLICIES AND PROCEDURES</u>		
STANDARD 15.3.1	<u>STANDARD 15.3.1</u> <i>There are written and dated policies and procedures that reflect current knowledge and principles of laboratory practice. They are consistent with statutory requirements and the objectives of the Pathology Services. There are current Laboratory User Manual and documented Standard Operating Procedures Manual available for staff reference.</i>		
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT
			SURVEYOR RATING
15.3.1.1 CORE	There are written policies and procedures for each unit of the Pathology Services that reflect the roles of the Facility and guide the activities of Pathology Services. They are consistent with the overall policies-of the Facility, regulatory requirements and current standard practices. The policies and procedures include but not limited to the following: a) the conduct of professional activities in accordance with the ethical standards of the professions involved; b) provide ready but controlled access to laboratory results; c) introduction of new tests, improvement on techniques, and undertaking research, where appropriate; d) provision of services on a 24-hour basis; e) contribution to the provision of high quality patient care by assisting in the review and evaluation of clinical practice within the Facility; f) provision of consultative service for the medical profession and other relevant staff in the selection of the laboratory investigations, their interpretation, and repeat test if required; g) communication with medical, nursing, and other relevant staff on matters related to the services provided. h) internal and external disaster plan; i) identify, assess and manage risks. These policies and procedures are signed, authorised and dated. There is a mechanism for and evidence of a periodic review at least once in every three years.		

	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for the service include but not limited to items (a) to (g).				
		2. Policies and procedures are consistent with the regulatory requirements and current standard practices.				
		3. Evidence of periodic review of policies and procedures.				
		4. The policies and procedures are endorsed and dated.				
		Facility Comments:				
15.3.1.2	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved. Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.					
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.				
		2. Minutes of meeting with evidence of cross reference with other departments				
		3. Documented cross departmental policies				
	Facility Comments:					
15.3.1.3	Current policies and procedures are communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings				
		2. Circulation list and acknowledgement				
	Facility Comments:					
15.3.1.4 CORE	There is EVIDENCE OF COMPLIANCE with policies and procedures.					
	EVIDENCE OF COMPLIANCE	1.Compliance with policies and procedures through:				
		a) interview of staff on practices;				
		b) verify with observation on practices;				
		c) results of audit on practices;				

		d) practices in line with established policies and procedures				
		Facility Comments:				
15.3.1.5		Copies of policies and procedures including Standard Operating Procedure Manual, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible for staff reference.				
	EVIDENCE OF COMPLIANCE	1. Copies of policies and procedures including Standard Operating Procedure Manual, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.				
		Facility Comments:				
15.3.1.6		There are policies and procedures relating to requests for laboratory tests which include: a) authorised person; b) written confirmation of all verbal requests; c) identification of the patient by full name, medical record number, date of birth, sex, identity card (IC) number; d) relevant medical history of patient; e) relevant medications of patient; f) tests requested; g) name of the requesting doctor; h) identification of the nature of the specimen on the request form and clear labelling of specimens requiring precautionary handling.				
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures relating to requests for laboratory tests which include items listed (a) to (h).				
		Facility Comments:				
15.3.1.7		There are written instructions for the proper collection, labelling, storage, preservation and transportation of specimens; and safety measures to be observed. These instructions are readily accessible to all staff who may be involved in obtaining specimens from patients.				

	EVIDENCE OF COMPLIANCE	1. Laboratory User Manual/User guide is available in hard/softcopy.				
		2. Distribution list of item (1).				
		3. Verification of practice during survey				
	Facility Comments:					
15.3.1.8	Complete records are kept of all specimens received by the laboratory. These are accurately identified and retrievable in the laboratory:					
	a) records on specimens received and forwarded to other laboratories;					
	b) there are written policies determining the length of time for which reports and specimens are retained.					
	EVIDENCE OF COMPLIANCE	1. Complete records for specimens received and forwarded to other laboratories;				
		2. Policies determining the length of time for which reports and specimens are retained.				
	Facility Comments:					
15.3.1.9	All pathology reports of investigations done on-site or off-site are included in the patient's medical record:					
	a) copies of all pathology reports are promptly sent to be reviewed and filed in the patient's medical record.					
	b) report/forms/results are designed to facilitate comparison of sequential tests/reports.					
	EVIDENCE OF COMPLIANCE	1. Evidences of (a) and (b) in patient's medical record.				
	Facility Comments:					
15.3.1.10	There is provision for immediate communication of results with critical range.					

	EVIDENCE OF COMPLIANCE	1. Policy on management of critical laboratory results				
		2. Evidence of communication of the critical level to the requesting medical practitioner/specialist/unit/ward.				
	Facility Comments:					
15.3.1.11	When reports are communicated through telephone or similar means, documentation is available.					
	a) the responsibility of receiving the report by phone is delegated to a responsible staff;					
	b) a hard copy of the report shall follow with minimum delay;					
	c) a documented system records the following:					
	i) the person providing the report;					
	ii) the person receiving the report;					
	iii) patient identity;					
iv) pathology results;						
v) date and time of receipt.						
EVIDENCE OF COMPLIANCE	1. Standard operating procedures for releasing the result.					
	2. Copy of laboratory report in patient's medical record					
	3. Records on (c)(i) to (c)(v).					
Facility Comments:						
15.3.1.12	Frozen section reports are transmitted directly to the surgeon concerned and followed by a written report.					
	EVIDENCE OF COMPLIANCE	1. Evidence of communication with respective surgeon				
		2. Written report in patient's medical record				
	Facility Comments:					
15.3.1.13	There are written safety procedures specific to the Pathology Services.					

	EVIDENCE OF COMPLIANCE	1. Documented safety procedures specific to the Pathology Services.				
	Facility Comments:					
15.3.1.14	There is evidence that all pathology staff practice Standard Precautions and Safety Guidelines.					
	EVIDENCE OF COMPLIANCE	1. Records on training on Standard Precautions and Safety Guidelines				
		2. Compliance of Standard Precautions and Safety Guidelines.				
	Facility Comments:					
15.3.1.15	There is a manual on pathology hazards and safety.					
	EVIDENCE OF COMPLIANCE	1. Authorised and dated Pathology Safety Manual.				
		Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT							
TOPIC 15.4:		<u>FACILITIES AND EQUIPMENT</u>					
<u>STANDARD 15.4.1</u>		<i>Adequate facilities and equipment are available for the safe and efficient provision of Pathology Services taking into consideration the potentially hazardous circumstances of the operations.</i>					
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
15.4.1.1	The office is separated from the technical laboratory area.						
	EVIDENCE OF COMPLIANCE	1. On-site observation of office space complies with the above.					
		2. Layout of laboratory as per set requirements.					
		Facility Comments:					
15.4.1.2	There are designated areas for handling of potentially hazardous specimen.						
	EVIDENCE OF COMPLIANCE	1. Designated areas includes:					
		a) reception;					
		b) separation;					
		c) storage;					
		d) dispatch.					
	Facility Comments:						
15.4.1.3	Work benches shall be adequately spaced and arranged in such a way as to ensure safety and efficiency in the use of equipment in accordance with manufacturer's recommendation and safety regulations.						

	EVIDENCE OF COMPLIANCE	1. On-site observation evidenced on:				
		a) adequately spaced work benches;				
		b) equipment arrangement ensures safety and efficiency of the laboratory's operation.				
	Facility Comments:					
15.4.1.4	There are adequate and proper storage areas of reagents, tissue specimens, consumables and other materials					
	EVIDENCE OF COMPLIANCE	1. On-site observation evidenced on:				
		a) adequate storage areas;				
		b) designated storage area for reagents, tissue specimens, consumables and other materials.				
	Facility Comments:					
15.4.1.5	There are separate and suitable stores for inflammable solvents and acid.					
	EVIDENCE OF COMPLIANCE	1. Separate storage for inflammables and acids according to set regulations.				
	Facility Comments:					
15.4.1.6	There are suitably located staff facilities for emergency shower and eye wash, changing room, locker facilities and storage for protective clothing.					
	EVIDENCE OF COMPLIANCE	1. Availability of:				
		a) emergency shower;				
		b) eye wash;				
		c) locker facilities;				
		d) storage for protective clothing.				
	Facility Comments:					

15.4.1.7	There is suitable, adequate and safe provision for air conditioning, ventilation, lighting, power, gases, water and drainage in the laboratory. These include the following: a) air conditioning shall be efficient to maintain low humidity, constant and comfortable room temperature; b) adequate ventilation with fume extraction, where appropriate; c) power supply shall be adequate, and there are sufficient suitably located power sockets; d) adequate and appropriate lighting; e) supply and use of gases shall follow current safety regulations; f) regular supply of distilled and deionised water for laboratory use.					
	EVIDENCE OF COMPLIANCE	1. Provisions for (a) to (f) are available on-site.				
	Facility Comments:					
15.4.1.8 CORE	The pathology equipment are appropriate and adequate to meet the demands of the service and are properly maintained.					
	EVIDENCE OF COMPLIANCE	1. Adequate equipment				
		2. Appropriate equipment commensurate with the scope of services provided				
		3. Proper equipment maintenance				
		4. Back-up system				
	Facility Comments:					
15.4.1.9 CORE	The laboratory shall have adequate and appropriate data processing storage, retrieval system and communication facilities. There is a secure system for result/report submission.					
	EVIDENCE OF COMPLIANCE	1. Adequate and appropriate data processing storage				
		2. Easy retrieval of data.				
		3. Appropriate communication facilities				
		4. Secured system for result or report transmission				
	Facility Comments:					

15.4.1.10	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.					
	EVIDENCE OF COMPLIANCE	1. User training records				
		2. Competency assessment record				
		3. Letter of authorisation				
		4. List of staff trained and privileged to operate and maintain specialised equipment.				
Facility Comments:						
15.4.1.11	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.					
	EVIDENCE OF COMPLIANCE	1. Testing, commissioning and calibration records (certificates or stickers)				
		2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as EVIDENCE OF COMPLIANCE to the relevant standards and Acts.				
	Facility Comments:					
15.4.1.12	Inventory of equipment, reagents and consumables shall be maintained.					
	EVIDENCE OF COMPLIANCE	1. Record of equipment inventory				
		2. Record of reagent inventory				
		3. Record of consumable inventory				
	Facility Comments:					
15.4.1.13	Each equipment/instrument has a logbook and maintenance records and these shall be made available when required.					
	EVIDENCE OF COMPLIANCE	1. Equipment/Instrument log book				
		2. Equipment/Instrument maintenance record				
	Facility Comments:					

15.4.1.14 CORE	There is evidence that the facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.					
	EVIDENCE OF COMPLIANCE	1. Planned Preventive Maintenance records such as schedule, stickers, etc.				
		2. Planned Replacement Programme where applicable				
		3. Complaint records				
		4. Asset inventory				
	Facility Comments:					
15.4.1.15	There is evidence of general cleanliness in the laboratory.					
	EVIDENCE OF COMPLIANCE	1. Good housekeeping is evidenced.				
		2. Cleaning schedule				
	Facility Comments:					
15.4.1.16	There are proper facilities for the disposal of biohazard material as either effluent or containerised material.					
	EVIDENCE OF COMPLIANCE	1. Proper disposal of biohazard material as containerised material or effluent according to regulations evidenced on-site.				
		Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT					
TOPIC 15.5:		<u>SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES</u>			
STANDARD 15.5.1		<i>The Head of Pathology Services shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Pathology Services.</i>			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
15.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Pathology Services. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.				
	EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to (f)			
		2. Records on performance improvement activities.			
		3. Minutes of performance improvement meetings			
		4. Performance improvement studies			
		5. Records on innovation if available			
	Facility Comments:				
15.5.1.2	The Head of Pathology Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement to appropriate individual/personnel within the respective services.				
	EVIDENCE OF COMPLIANCE	1. Designated officer or committee assigned for performance improvement activities.			
		2. Designated safety officer or committee to monitor laboratory safety			
	Facility Comments:				

15.5.1.3	The Head of the Pathology Services shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility. Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.																												
	<table><tr><td rowspan="10">EVIDENCE OF COMPLIANCE</td><td colspan="2">1. System for incident reporting is in place, which include:</td></tr><tr><td>a) Training of staff</td><td></td></tr><tr><td>b) Policy on incident reporting</td><td></td></tr><tr><td>c) Methodology of incident reporting</td><td></td></tr><tr><td>d) Register/records of incidents</td><td></td></tr><tr><td colspan="2">2. Completed incident reports</td></tr><tr><td colspan="2">3. Root Cause Analysis</td></tr><tr><td colspan="2">4. Corrective and preventive action plans</td></tr><tr><td colspan="2">5. Remedial measure</td></tr><tr><td colspan="2">6. Minutes of meetings</td></tr><tr><td colspan="2">7. Acknowledgment by Head of Service and PIC/Hospital Director</td></tr><tr><td colspan="2">8. Feedback given to staff regarding incident reporting.</td></tr></table>	EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:		a) Training of staff		b) Policy on incident reporting		c) Methodology of incident reporting		d) Register/records of incidents		2. Completed incident reports		3. Root Cause Analysis		4. Corrective and preventive action plans		5. Remedial measure		6. Minutes of meetings		7. Acknowledgment by Head of Service and PIC/Hospital Director		8. Feedback given to staff regarding incident reporting.				
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8. Feedback given to staff regarding incident reporting.																													
	Facility Comments:																												
15.5.1.4 CORE	There is tracking and trending of specific performance indicators that covers the following: a) timeliness of urgent requests b) rejection rate of specimens (Target: <1%) c) notification of critical results. Targets of performance indicators shall meet patient care need of the Facility.																												
	<table><tr><td rowspan="3">EVIDENCE OF COMPLIANCE</td><td>1. Specific performance indicators monitored.</td><td></td></tr><tr><td>2. Records on tracking and trending analysis.</td><td></td></tr><tr><td>3. Remedial measures taken where appropriate.</td><td></td></tr></table>	EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored.		2. Records on tracking and trending analysis.		3. Remedial measures taken where appropriate.																						
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	3. Remedial measures taken where appropriate.																												
	Facility Comments:																												
15.5.1.5	The Pathology Services shall have quality control programme for all tests provided.																												

	EVIDENCE OF COMPLIANCE	1. Internal Quality Control (IQC) Programme				
		2. External Quality Assurance (EQA) Programme				
	Facility Comments:					
15.5.1.6	The results of the internal and external quality programmes shall be available and readily understood by relevant staff.					
	EVIDENCE OF COMPLIANCE	1. Evidence of participation in IQC and EQA.				
		2. Performance reviewed				
		3. Documented evidence of discussion.				
	Facility Comments:					
15.5.1.7	There shall be evidence of corrective and preventive actions for any shortfall in quality.					
	EVIDENCE OF COMPLIANCE	1. Evidence of corrective actions				
		2. Evidence of preventive actions				
	Facility Comments:					
	15.5.1.8	Pathology staff shall participate in clinical audit activities with other clinical specialties.				
EVIDENCE OF COMPLIANCE		1. Evidence of participation in clinical audit activities with other services, i.e. mortality and morbidity audits.				
Facility Comments:						
15.5.1.9	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.					

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

SERVICE SUMMARY	
SURVEYOR SUMMARY:	
OVERALL RATING:	
OVERALL RISK:	

SURVEY ITEM & SELF-ASSESSMENT						
SERVICE STANDARD 16 : BLOOD TRANSFUSION SERVICES						
	<u>PREAMBLE</u> <i>Blood Transfusion Services may be provided from within, or external to the Facility. This Standard is applicable to Facilities where blood transfusion services are provided to patients. These services may include blood donation, blood component preparation, screening and release of blood and blood components, blood inventory management and immuno-haematology services which cover pre-transfusion testing, antibody screening and identification, and investigation of transfusion reaction.</i>					
<u>TOPIC 16.1:</u> <u>STANDARD 16.1.1</u>	<u>ORGANISATION AND MANAGEMENT</u> <i>The Blood Transfusion Services shall be organised and administered to provide safe donation and transfusion of blood and blood components appropriate to the level of clinical services provided by the Facility. The Head of the Blood Transfusion Services shall be a medical practitioner with training and experience in blood transfusion services.</i>					
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
16.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Blood Transfusion Services are clearly documented and measurable that indicates safety, quality and patient centred care. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.				
		2. Goals and objectives of the Blood Transfusion Services in line with the Facility statements are available, endorsed and dated.				
		3. Evidence of planned reviews of the above statements.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)				
		5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.				
	Facility Comments:					
16.1.1.2 CORE	There is an organisation chart which:					
	a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head and staff of the Blood Transfusion Services;					
	b) is accessible to all staff and clients;					
	c) includes off-site services if applicable;					
	d) is revised when there is a major change in any of the following:					
	i) organisation;					
	ii) functions;					
	iii) reporting relationships;					
	iv) staffing patterns.					
	EVIDENCE OF COMPLIANCE	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head and staff of the Blood Transfusion Services.				
		2. Organisation chart of the service is endorsed, dated and accessible.				
		3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).				
	Facility Comments:					
16.1.1.3	Regular staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Blood Transfusion Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	EVIDENCE OF COMPLIANCE	1. Minutes are accessible, disseminated and acknowledged by the staff.						
		2. Attendance list of members with adequate representatives of the service.						
		3. Frequency of meetings as scheduled.						
		4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).						
	Facility Comments:							
16.1.1.4	The Head of Blood Transfusion Services is involved in the planning, justification and management of the budget and resource utilisation of the services.							
	EVIDENCE OF COMPLIANCE	1. Minutes of Facility-wide management meeting						
		2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service.						
		3. Approved budget and resources.						
	Facility Comments:							
16.1.1.5	The Facility shall establish a Transfusion Committee to review practices and policies with regard to blood supply and usage. The Transfusion Committee:							
	a) is chaired by the Person In Charge (PIC)/appointed senior clinician and members include representatives from Blood Transfusion Services and main clinical services with significant transfusion activities;							
	b) has Terms of Reference of the Transfusion Committee that shall include to:							
	i) define blood transfusion policies adapted to the local clinical activities;							
	ii) conduct regular review of blood transfusion practices;							
	iii) analyse any adverse events due to blood donation and transfusion;							

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	iv) take any preventive and corrective measures if necessary; v) ensure all staff involved in transfusion chain receive adequate training.					
	EVIDENCE OF COMPLIANCE	1. Letters of appointment/assignment				
		2. Terms of Reference of Transfusion Committee				
		3. Minutes of Transfusion Committee meeting				
	Facility Comments:					
16.1.1.6	The Head of Blood Transfusion Services is involved in the appointment and/OR assignment of the staff.					
	EVIDENCE OF COMPLIANCE	1. Records on staff interview (if applicable)				
		2. Appointment/assignment letter of Head of Service				
		3. Job description of Head of Service				
		4. Records on staff deployment				
		5. Duty roster				
	Facility Comments:					
16.1.1.7	Appropriate statistics and records shall be maintained for defined retention periods in relation to the provision of Blood Transfusion Services and used for managing the services and patient care purposes.					
	If blood collection activities are carried out within the Facility, appropriate donor statistics and records shall be maintained as above.					
	EVIDENCE OF COMPLIANCE	1.Records are available but not limited to the following:				
		a) workload/census;				
	b) annual report;					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		c) accident/incident reports;				
		d) donation records;				
		e) transfusion records;				
		f) staffing number and staff profile;				
		g) staff training records;				
		h) data on performance improvement activities, including performance indicators.				
	Facility Comments:					
16.1.1.8	Where any part of the services is provided in areas within the Facility other than in the Blood Transfusion Services, responsibility for the operations of those services is clearly defined. Staff are trained, given appropriate instructions and closely supervised to operate these services. The appropriate equipment is properly maintained and quality control is carried out and documented. Notes/Explanations These services include the following: i. Storage. ii. Transport.					
EVIDENCE OF COMPLIANCE	1. Records are available for the following:					
	a) Training and competency records					
	b) Equipment maintenance records					
	c) Records on quality control measures					
Facility Comments:						

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
STANDARD 16.1.2	<i>Facilities that do not provide a full range of Blood Transfusion Services shall arrange with an external source to provide the services needed.</i>				
16.1.2.1	The Blood Transfusion Services provided by an external source shall comply with all relevant MSQH Standards of Accreditation.				
	EVIDENCE OF COMPLIANCE	1. Certification of accreditation for the following:			
		a) Department of Standards Malaysia (ISO MS 15189) and			
		b) MSQH Standards of accreditation			
		a) Compliance to current Good Manufacturing Practice (cGMP) standards			
	Facility Comments:				
16.1.2.2 CORE	Where services are provided from an external source, there is a written agreement between the external service provider and the Facility stating the requirements for service delivery, including the following but not limited to: a) formal lines of communication, responsibilities and reporting between the external service provider and the Facility; b) staff providing the services are appropriately qualified; c) requirement for written requests; d) effective and safe handling and transport of specimens, blood and blood products; e) arrangements for after-hours and emergency services; f) the external service provider shall have a quality system in place.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. There is written agreement with the external service provider and the Facility specifying items (a) to (f).				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 16.2		HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT				
STANDARD 16.2.1		The Blood Transfusion Services shall be headed by a registered medical practitioner with training and experience in Transfusion Medicine/ Haematopathology/Haematology. The day-to-day operations of the service may be delegated to a suitably qualified and experienced officer, supported by appropriately qualified staff.				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
16.2.1.1 CORE	The direction and overall supervision of the Blood Transfusion Services shall be by a Head who is a registered medical practitioner with training and experience in Transfusion Medicine/ Haematopathology/Haematology. There is evidence that the medical practitioner is actively practicing as evidenced by:					
	a) being responsible for 24 hours cover for the Blood Transfusion Services;					
	b) ensuring and participating in continuing medical education programme.					
	EVIDENCE OF COMPLIANCE	1. Appointment/assignment letter				
		2. Job description				
		3. Primary qualifications of the Head of Blood Transfusion Services.				
		4. Valid professional Annual Practising Certificate (APC)				
		5. Documentation of participation in continuing medical education and meeting				
Facility Comments:						
16.2.1.2	The authority, responsibilities and accountabilities of the Head of Blood Transfusion Services are clearly delineated and documented.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	EVIDENCE OF COMPLIANCE	1. Appointment/assignment letter for Head of Service.						
		2. Description of duties and responsibilities						
	Facility Comments:							
16.2.1.3	The staffing of the Blood Transfusion Services is provided by individuals qualified by education, training, and experience and certification to meet the demands of the various positions and to achieve the scope of the services.							
	EVIDENCE OF COMPLIANCE	1. The medical/nursing staff in Blood Transfusion Services shall have a valid professional Annual Practising Certificate (APC).						
		2. Experience of the staff of Blood Transfusion Services shall meet the demand of their positions, the scope and complexity of the Blood Transfusion Services activities. Staff credentials and privileges.						
		3. Current assigned duty roster						
	Facility Comments:							
16.2.1.4	Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the need of the services.							
	Notes/Explanations Staff are properly trained and qualified to perform the task that are required of them. The number of staff employed shall commensurate with the workload of the Blood Transfusion Services.							

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Number of staff and qualification commensurate with workload.				
		2. Staffing pattern				
		3. Duty roster				
		4. Census and statistics				
	Facility Comments:					
16.2.1.5	There are written and dated specific job descriptions for all categories of staff that include: a) qualifications, training, experience and certification required for the position; b) lines of authority; c) accountability, functions and responsibilities, d) reviewed when required and when there is a major change in any one of the following: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations. e) administrative and clinical functions.					
EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e).					
	2. Job description includes specialisation skills					
	3. Relevant privileges granted where applicable					
	4. The job description is acknowledged by the staff and signed by the Head of Service and dated.					
Facility Comments:						

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
16.2.1.6	Personnel records on training, staff development, leave and others are maintained for every staff. Note: <i>Staff personal record may be kept in Human Resource Department as per Facility policy.</i>			
	1. Staff personal records include:			
	a) staff biodata;			
	b) qualification and experience;			
	c) evidence of current registration;			
	d) training record;			
	e) competency record and privileging;			
	f) leave record;			
	g) incidents at work;			
	h) confidentiality agreement;			
	i) health screening status;			
	j) immunisation status.			
	Facility Comments:			
16.2.1.7	There is a structured orientation programme and on-the-job training to introduce new staff to the Blood Transfusion Services, operational policies and relevant aspects of the Facility to prepare them for their roles and responsibilities. This include but not limited to: a) rules and regulations on Blood Transfusion Services; b) policies and procedures on all aspects of Blood Transfusion Services; c) all relevant manuals on hazards and safety precautions including requirements for immunisation against certain infections.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme.				
		2. There is Blood Transfusion Services orientation programme with relevant topics not limited to topics covered from (a) to (c).				
		3. Attendance list				
Facility Comments:						
16.2.1.8	There is evidence of training needs assessment and staff development plan which provides the knowledge and skills required for staff to maintain competency in their current positions and future advancement.					
	EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and gaps identified.				
		2. A staff development plan based on training needs assessment is available.				
		3. Training schedule/calendar is in place.				
		4. Training module				
Facility Comments:						
16.2.1.9	There are continuing education activities for staff including medical practitioners to pursue professional interests and to prepare for current and future changes in practice.					
	EVIDENCE OF COMPLIANCE	1. Training calendar includes in-house/external courses/workshop/conferences				
		2. Contents of training programme				
		3. Training records on continuing education activities are kept and maintained for each staff including training in life support.				
		4. Certificate of attendance/degree/post basic training.				
Facility Comments:						

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
16.2.1.10	Staff including medical practitioners shall receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.					
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff including medical practitioners are completed upon probationary period and as an annual exercise.				
	Facility Comments:					
16.2.1.11	The Blood Transfusion Services shall provide a continuing education programme for non-transfusion services health professional staff to keep them informed of updates and advances in blood transfusion and related fields.					
	EVIDENCE OF COMPLIANCE	1. Records on continuing education activities for non-transfusion services health professional staff.				
		2. Records on attendance				
	Facility Comments:					
16.2.1.12	The functions of the Blood Transfusion Services include continuous professional development, where relevant, as well as research projects and special studies, as appropriate.					
	EVIDENCE OF COMPLIANCE	1. Records on training				
		2. Records on research projects and special studies if available.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT				
TOPIC 16.3	<u>POLICIES AND PROCEDURES</u>			
STANDARD 16.3.1	<i>There are written and dated policies and procedures that reflect current knowledge and principles of blood transfusion practice. They are consistent with statutory requirements and the objectives of the Blood Transfusion Services. There are Standard Operating Procedures (SOPs), consistent with current policy and guidelines: National Policy for Blood Transfusion Services in Malaysia, Transfusion Practice Guidelines for Clinical and Laboratory Personnel and Guideline for the Rational Use of Blood and Blood Products by the Ministry of Health Malaysia, available for staff reference.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
16.3.1.1 CORE	There are written policies and procedures for each area of the Blood Transfusion Services that reflect the roles of the Facility and guide the activities of Blood Transfusion Services. They are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. The policies and procedures include but not limited to the following: a) the conduct of professional activities in accordance with the ethical standards of the professions involved and code of ethics in transfusion; b) provision of services on a 24-hour basis, where necessary; c) provision of quality care to blood donors and patients who receive transfusion; d) provision of consultative service for the medical profession and other relevant staff on the appropriate use of blood and blood products and in the selection of the laboratory investigations, their interpretation and repeat of tests if required; e) communication and collaboration with clinical and other relevant staff on matters related to the services provided. These policies and procedures are signed, authorised and dated. There is a mechanism for and evidence of a periodic review at least once in every three years.			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for the service include items (a) to (e).			
		2. Policies and procedures are consistent with regulatory requirements and current standard practices.			
		3. Evidence of periodic review of policies and procedures.			
		4. The policies and procedures are endorsed and dated.			
		5. Written ethical standards for professions and transfusion.			
		6. Donor acceptance and deferral criteria			
		7. Donor Registration Form			
		8. Standard operating procedures on donor management – pre-donation, donation and post donation			
		9. Records on blood request forms			
		10. Records on blood transfusion in patient medical records			
		11. Standard operating procedures on transfusion – blood sampling and labelling, blood administration, management of adverse transfusion reactions.			
		12. Training and competency records			
	Facility Comments:				
16.3.1.2 CORE	There are policies and procedures for blood donation that include: a) donor declaration and consent for donation shall be obtained and maintained; b) blood donation shall be on a voluntary and non-remunerated basis and payment for blood donated shall not be allowed; c) directed blood donation by the family members is not recommended except in special circumstances;				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	d) criteria for donor acceptance shall be in accordance to current guidelines; e) blood donation shall not be allowed from donors with high risk behaviours; f) all blood collected shall be clearly and uniquely identified and traceable to the donors.					
	EVIDENCE OF COMPLIANCE				1. Policies and procedures for blood donation include items (a) to (f).	
					2. Donation and donor database	
					3. Blood donation consents	
	Facility Comments:					
16.3.1.3 CORE	There are policies and procedures for screening of blood for Transfusion Transmissible Infections (TTIs): a) mandatory screening for HIV, Hepatitis B, Hepatitis C and Syphilis shall be performed on all donated blood; b) technology and methodology of the tests to be followed shall be based on current guideline; c) only blood screened negative for TTIs shall be released for use; d) unscreened blood shall not be used for transfusion.					
	EVIDENCE OF COMPLIANCE				1. Policies and procedures for screening of blood for Transfusion Transmissible Infections (TTIs) include items (a) to (d).	
					2. Enzyme Immune Assay (EIA) is performed for HIV, Hepatitis B, Hepatitis C screening.	
					3. Records on screening results	
					4. Blood release records	
Facility Comments:						

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
16.3.1.4 CORE	There are policies and procedures for blood component preparation as follows: a) donated blood shall be processed into suitable blood components for use; b) blood component preparation shall be in accordance with national standards and current Good Manufacturing Practice (cGMP); c) proper equipment, validated and maintained shall be used to process components; d) regular quality control shall be carried out to ensure quality of components.			
	EVIDENCE OF COMPLIANCE			
	1. Standard operating procedures for blood component preparation.			
	2. Records on types of components prepared			
	3. Records on quality control (QC) of components prepared.			
	4. Records on equipment maintenance			
	Facility Comments:			
16.3.1.5 CORE	There are policies and procedures for blood inventory management as follows: a) proper storage and transport of blood and blood products shall follow current Good Manufacturing Practice (cGMP) and Good Distribution Practice (GDP) to ensure blood cold chain is maintained at all times; b) a minimum quantity of blood and blood components appropriate to the level and type of services offered by the Facility shall be maintained at all times; c) an inventory management system shall be established and should include contingency plans during shortages; d) expired and unsuitable blood and blood components shall be appropriately disposed of.			
	EVIDENCE OF COMPLIANCE			
	1. Policies and procedures for blood inventory management include items (a) to (d).			
	2. Records on temperature monitoring during storage and transport			
	3. Records on discarded blood and blood components.			
	Facility Comments:			

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
16.3.1.6 CORE	There are policies and procedures for immunohaematology as follows:			
	a) processes and procedures shall be put in place to ensure only safe and compatible blood and blood components are issued to all patients;			
	b) ABO and Rh typing shall be carried out and documented for all donated blood in accordance to national guideline;			
	c) antibody screening shall be performed on patients and documented;			
	d) patient's ABO and Rh typing shall be determined, and screening for red cell antibodies shall be performed. Compatibility testing shall be performed prior to transfusion and documented;			
	e) all near misses, incorrect blood component transfused (IBCT) and ABO discrepancies shall be investigated and documented.			
EVIDENCE OF COMPLIANCE	1. Policies and procedures for immunohaematology include items (a) to (e).			
	2. Records on ABO and Rh grouping for donated blood			
	3. Records on pre-transfusion testing for patient			
Facility Comments:				
16.3.1.7	There are policies and procedures for Clinical Transfusion Practice as follows:			
	a) Informed consent for transfusion shall be obtained by registered medical practitioner and maintained.			
	b) There are policies and procedures relating to requests for blood transfusion including:			
	i) only registered medical practitioners are authorised to prescribe and request for blood transfusion;			
	ii) identification of the patient by identity card (IC) number/passport number, full name, medical record number			
	iii) signature and name of the requesting medical practitioner;			

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	iv) blood components and blood products requested; v) relevant medical history of patient and the indication for transfusion; vi) signature and name of the staff who performed the blood sampling and labelling; vii) the specimen shall be clearly and correctly labeled. c) There are policies and procedures relating to the administration of blood and blood components including: i) prior to administration of blood and blood components, all information identifying the blood for the intended recipient shall be verified according to the checklist as stipulated in the national guideline; ii) transfusion therapy is under the overall responsibility of a registered medical practitioner; iii) signature and name of the staff who performed the administration of blood and/or components; iv) all patients receiving transfusion of blood or blood components shall be monitored during and after the transfusion process; v) all near misses shall be managed appropriately, documented and reported; vi) all adverse events shall be managed appropriately, documented and reported to the Transfusion Committee and National Haemovigilance Coordinating Centre (NHCCC). d) All transfusion records shall be included in the patient's medical record in accordance to defined retention periods.			
	EVIDENCE OF COMPLIANCE			
	1. Documentation of informed consent in patient's medical record.			
	2. Record of blood transfusion request			
	3. Record of blood transfusion checklist			
	4. Record of adverse events and near misses in relation to blood transfusion			
	Facility Comments:			

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
16.3.1.8	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved. Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.					
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.				
		2. Minutes of meeting with evidence of cross reference with other departments				
		3. Documented cross departmental policies				
	Facility Comments:					
16.3.1.9	Current policies and procedures are communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings				
		2. Circulation list and acknowledgement				
	Facility Comments:					
16.3.1.10	Copies of policies and procedures including Standard Operating Procedure Manual, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible for staff reference.					
	EVIDENCE OF COMPLIANCE	1. Copies of policies and procedures including Standard Operating Procedure Manual, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.				
		Facility Comments:				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
16.3.1.11	The following records shall be kept in accordance to defined retention periods to ensure traceability and accountability: a) blood specimens received from other facilities; b) blood issued to patients for transfusion; c) blood received from other facilities; d) blood issued to other facilities.				
	EVIDENCE OF COMPLIANCE	1. Records on the following are available and maintained in according to retention periods.			
		a) blood specimens received;			
		b) blood issued to patients for transfusion;			
		c) blood received from other facilities;			
		d) blood issued to other facilities.			
	Facility Comments:				
16.3.1.12	There are policies and procedures on Haemovigilance as follows: a) adverse events relating to blood donation and transfusion; b) lookback and recall for seroconvert donor/recipient. All adverse events and seroconvert cases shall be investigated, documented and reported; c) reports shall be reviewed periodically by the Facility Transfusion Committee for preventive and corrective action and reported to National Haemovigilance Coordinating Centre (NHCCC), National Blood Centre, Ministry of Health.				
	EVIDENCE OF COMPLIANCE	1. Standard operating procedures on management of reporting of adverse events			
		2. Standard operating procedures on look back and recall with management of these cases.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		3. Minutes Facility Transfusion Committee on Haemovigilance.				
	Facility Comments:					
16.3.1.13	There are written standard precautions and safety guidelines for Blood Transfusion Services. All blood transfusion staff shall adhere to these standard precautions and safety guidelines.					
EVIDENCE OF COMPLIANCE	1. Standard Precautions and Safety Guidelines					
	2. Training records on standard precautions and safety guidelines.					
Facility Comments:						

SURVEY ITEM & SELF-ASSESSMENT					
TOPIC 16.4 FACILITIES AND EQUIPMENT STANDARD 16.4.1 <i>There are adequate facilities and equipment for the safe and efficient provision of Blood Transfusion Services.</i>					
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
16.4.1.1	The administrative, blood donation, blood component, blood procurement, processing, screening, testing, storage and technical laboratory areas are separate.				
	EVIDENCE OF COMPLIANCE	1. There are designated areas for:			
		a) administrative functions;			
		b) blood donation;			
		c) blood component;			
		d) blood procurement;			
		e) processing;			
		f) screening;			
		g) testing;			
		h) storage;			
		i) technical laboratory areas.			
	Facility Comments:				
16.4.1.2	Technical work areas shall be adequately spaced out and arranged in such a way to facilitate workflow to ensure safety and efficiency.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. On-site observation to verify layout of facility complies with safety requirements.				
		2. Unidirectional flow of blood donors, blood samples and blood components.				
	Facility Comments:					
16.4.1.3	There are adequate storage facilities and equipment which comply with current regulations and guidelines. The storage facilities include: a) adequate and proper storage space for reagents, consumables, and other materials; b) sufficient space and refrigeration for storage of blood and blood components with proper records; c) screened and unscreened blood and blood components shall be kept in separate refrigerators and freezers respectively; d) temperature control of all blood refrigerators, freezers and platelet agitators shall be monitored and documented.					
EVIDENCE OF COMPLIANCE	1. Adequate facilities and proper utilisation of space within the Facility.					
	a) Clear exit route					
	b) No over crowding					
	2. Adequate storage space					
	3. Record of temperature monitoring					
	4. Dedicated refrigerators and freezers for screened and unscreened blood and blood components.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		5. Records of alarm checks carried out for blood refrigerators, freezers and platelet agitators.				
	Facility Comments:					
16.4.1.4	All blood that has been screened and found reactive shall be removed from the stock. All tainted blood bags shall be autoclaved and subsequently incinerated.					
	EVIDENCE OF COMPLIANCE	1. Standard operating procedures for disposal of reactive donations				
		2. Records on disposal due to reactive donations				
	Facility Comments:					
16.4.1.5	There are suitably located staff facilities with locker facilities and staff are provided with appropriate personal protective clothing.					
	EVIDENCE OF COMPLIANCE	1. Appropriate Personal Protective Equipment (PPE) available.				
		2. Staff facilities, i.e. lockers.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
16.4.1.6	There is suitable, adequate and safe provision for air conditioning, ventilation, lighting, power, gases, water and drainage, which include the following: a) air conditioning shall be efficient to maintain low humidity, constant and comfortable room temperature; b) power supply shall be adequate with sufficient suitably located power outlets; c) adequate and appropriate lighting; d) alarm and emergency power supply for critical equipment including but not limited to refrigerators for blood and blood products, freezers platelet agitators and apheresis machines.					
	EVIDENCE OF COMPLIANCE				1. Provisions for items (a) to (d) are available on-site.	
					2. Record of ambient temperature monitoring in appropriate locations such as component processing area, etc.	
	Facility Comments:					
16.4.1.7	Equipment are appropriate and adequate to meet the scope of the services.					
	EVIDENCE OF COMPLIANCE				1. Adequate equipment	
					2. Appropriate equipment commensurate with the scope of services provided	
	Facility Comments:					
16.4.1.8	The Blood Transfusion Services shall have adequate and appropriate information management system and communication facilities.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Bidirectional traceability and audit trail is available.				
	Facility Comments:					
16.4.1.9	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.					
	EVIDENCE OF COMPLIANCE	1. User training records				
		2. Competency assessment record				
		3. Letter of authorisation				
		4. List of staff trained and authorised to operate specialised equipment				
	Facility Comments:					
16.4.1.10	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.					
	EVIDENCE OF COMPLIANCE	1. Testing, commissioning and calibration records (certificates or stickers).				
		2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as evidence of compliance to the relevant standards and Acts, e.g. Medical Device Authority certification.				
	Facility Comments:					
16.4.1.11	Each equipment shall have a logbook and maintenance record.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	EVIDENCE OF COMPLIANCE	1. Equipment log book						
		2. Equipment maintenance record						
	Facility Comments:							
16.4.1.12 CORE	There is evidence that the Facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.							
	EVIDENCE OF COMPLIANCE	1. Planned Preventive Maintenance records such as schedule, stickers, etc.						
		2. Planned Replacement Programme where applicable						
		3. Complaint records						
		4. Asset inventory						
	Facility Comments:							
16.4.1.13	Cleanliness in the Blood Transfusion Services shall be maintained at all times.							
	EVIDENCE OF COMPLIANCE	1. Good housekeeping is evidenced.						
		2. Cleaning records						
	Facility Comments:							
16.4.1.14	There are proper facilities for the disposal of biohazard wastes.							

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Proper facilities for disposal of biohazard wastes.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT								
<u>TOPIC 16.5</u>		<u>SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES</u>						
<u>STANDARD 16.5.1</u>		<i>The Head of Blood Transfusion Services shall ensure the provision of safe and adequate blood and components with staff involvement in the continuous safety and performance improvement activities of the Blood Transfusion Services.</i>						
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS				
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING			
16.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Blood Transfusion Services. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.							
	EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to (f)						
		2. Records on performance improvement activities						
		3. Minutes of performance improvement meetings						
		4. Performance improvement studies						
		5. Records on innovation if available						
	Facility Comments:							
16.5.1.2	The Head of the Blood Transfusion Services has assigned responsibilities to appropriate individuals/team/committees for safety, quality assurance, performance improvement and risk management activities within the services.							

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	EVIDENCE OF COMPLIANCE	1. Assigned individual/committee for safety, risk management and quality assurance activities					
		2. Terms of Reference/Job description					
		3. Written document for safety and quality assurance activities, e.g. standard operating procedures, audit reports, proficiency testing. Quality control activities.					
		4. Minutes of meetings					
	Facility Comments:						
16.5.1.3	The Head of the Blood Transfusion Services shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility.						
	Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.						
	The Head of Blood Transfusion Services leads the team in the investigation and reporting of transfusion transmitted diseases.						
	EVIDENCE OF COMPLIANCE	1. System for incident reporting/adverse event reporting is in place, which include:					
		a) Training of staff					
		b) Policy on incident/adverse event reporting					
		c) Methodology of incident//adverse event reporting					
		d) Register/records of incidents/adverse event					
		2. Completed incident/adverse event reports					
		3. Root Cause Analysis					
		4. Corrective and preventive action plans					
		5. Remedial measure					
6. Minutes of meetings							

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
		7. Acknowledgment by Head of Service and PIC/Hospital Director					
		8. Feedback given to staff regarding incident reporting.					
	Facility Comments:						
16.5.1.4 CORE	There is tracking and trending of specific performance indicators not limited to but at least two (2) of the following. a) crossmatch to transfusion ratio (C:T ratio) (Target: ≤ 2.0) b) expiry rates of different blood components (Target: red cell: ≤ 2.5% platelet concentrates: ≤ 15% apheresis (platelet or plasma): 0%) c) number of adverse events in donors (adverse donor reactions and seroconversion) d) number of adverse events in patients [near misses, transfusion errors (Incorrect blood component transfused), transfusion reactions, transfusion transmitted infections] Notes/Explanations These specific indicators to be monitored depending on the scope of the services. The reports on indicators are available and submitted to the national coordinating agency (National Blood Centre, Ministry of Health).						
EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored.						
	2. Records on tracking and trending analysis.						
	3. Remedial measures taken where appropriate						
Facility Comments:							

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS			
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
16.5.1.5	The Blood Transfusion Services shall have relevant internal quality control programme and subscribe to approved external quality assessment. The results of the performance shall be communicated to the staff.						
	EVIDENCE OF COMPLIANCE	1. Records on Internal Quality Control (QC) and External Quality Assurance performance.					
		a) QC of tests performed					
		b) Proficiency testing (External quality assurance program)					
	Facility Comments:						
16.5.1.6	The feedback on results of quality assurance activities are regularly communicated to the staff.						
	EVIDENCE OF COMPLIANCE	1. Minutes of meeting					
		2. Staff acknowledgement documented in communication book.					
		3. Circulation of analysis report.					
	Facility Comments:						
16.5.1.7	Audit shall be carried out to cover processes and activities of the services.						
	EVIDENCE OF COMPLIANCE	1. Audit schedule.					
		2. Audit report.					
	Facility Comments:						

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
16.5.1.8	A Blood Transfusion Services officer shall be appointed to monitor laboratory safety and observance of standard precautions and safety guidelines.					
	EVIDENCE OF COMPLIANCE	1. Letter of appointment				
	Facility Comments:					
16.5.1.9	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff, donors and patients are preserved.					
	EVIDENCE OF COMPLIANCE	1. Documentation on performance improvement activities and performance indicators.				
		2. Policy statement on anonymity on donors and patients involved in performance improvement activities.				
	Facility Comments:					

SERVICE SUMMARY	
SURVEYOR SUMMARY:	
OVERALL RATING:	
OVERALL RISK:	

SURVEY ITEM & SELF-ASSESSMENT				
SERVICE STANDARD 17 : REHABILITATION MEDICINE SERVICES				
	<u>PREAMBLE</u> <i>Rehabilitation Medicine Services are clinical speciality services offering inpatient as well as outpatient clinical care and rehabilitation for individuals whose abilities have been limited by disease, trauma or congenital disorders.</i> <i>It is a medical specialty concerned with evaluation, diagnosis and management of individuals of all ages with physical and cognitive impairment resulting in disability. This specialty involves treatment of individuals with functional limitation emphasising on functional attainment while also addressing prevention of complication.</i> <i>Rehabilitation Medicine Specialist provide leadership to multidisciplinary teams concerned with optimal restoration of function via physical, psychological, social, occupational, vocational and avocational interventions.</i>			
<u>TOPIC 17.1:</u> <u>STANDARD 17.1.1</u>	<u>ORGANISATION AND MANAGEMENT</u> <i>The Rehabilitation Medicine Services shall be organised, directed and coordinated with other services in the Facility to provide a standard of inpatient and outpatient care to the community which is efficient, effective, and in a caring manner and with due regard for the needs, dignity and privacy of patients and confidentiality of their personal information. The Rehabilitation Medicine Services shall be easily accessible and continuity of care assured.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
17.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Rehabilitation Medicine Services are clearly documented and measurable that indicates safety, quality and patient centred care. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.				
		2. Goals and objectives of the Rehabilitation Medicine Services in line with the Facility statements are available, endorsed and dated.				
		3. Evidence of planned reviews of the above statements.				
		4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)				
		5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.				
	Facility Comments:					
17.1.1.2 CORE	There is an organisation chart which: a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head of the Rehabilitation Medicine Services, consultants, medical practitioners and staff of the Rehabilitation Medicine Services; b) reflect the link to relevant medical subspecialties services/units; c) is accessible to all staff and clients; d) is revised when there is a major change in any of the following: i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns.					
EVIDENCE OF COMPLIANCE	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head of the Rehabilitation Medicine Services, relevant medical subspecialties services/units, consultants, medical practitioners and staff of the Rehabilitation Medicine Services.					
	2. Organisation chart of the service is endorsed, dated and accessible.					
	3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv)					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS																		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING																	
	Facility Comments:																				
17.1.1.3	The Governing Body shall ensure that Rehabilitation Medicine Services are organised in such a way as to: a) facilitate the provision of rehabilitation medicine services to patients in the Facility in a safe, efficient, effective, and caring manner and with due regard for the needs, dignity and privacy of patients and confidentiality of their personal information; b) assure continuity of care; c) address the professional needs of the medical practitioners providing rehabilitation medicine services d) ensure that all medical practitioners are involved in the formulation of policies and procedures concerning patient care appropriate to the scope of services of the Facility.																				
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	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
17.1.1.4	There is a mechanism to ensure effective interaction between the Rehabilitation Medicine Services and the Governing Body and Management on all clinical aspects of healthcare and other relevant matters in the Facility. This mechanism is defined in the policies of the Governing Body and is accomplished through: a) the appointment of a rehabilitation medicine specialist as the Head of Rehabilitation Medicine Services delineating his/her authority, responsibilities and accountabilities in a written document according to the relevant Acts to manage and control the Rehabilitation Medicine Services; b) Medical and Dental Advisory Committee (MDAC) to advise the Governing Body on issues related to clinical governance, i.e. planning, coordinating, implementation, control and to improve activities relating to Rehabilitation Medicine Services.				
EVIDENCE OF COMPLIANCE	1. Letter of appointment and delineation of duties and responsibilities of the Head of Service.				
	2. Registration with National Specialist Register/Gazettement				
	3. Letter of appointment and Terms of Reference as member of the Medical and Dental Advisory Committee/Medical Advisory Committee.				
	4. Minutes of meetings of MDAC/Management				
Facility Comments:					
17.1.1.5	There is documented evidence of multidisciplinary, interdisciplinary or transdisciplinary team management of patients led by a Rehabilitation Medicine Specialist.				
EVIDENCE OF COMPLIANCE	1. Minutes of interdisciplinary meetings				
	2. Communication memos/interdisciplinary clinical meetings evidenced				
	3. Sample patient's medical records				
Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
17.1.1.6 CORE	The Head of Rehabilitation Medicine Services has: a) representation of the Service in committees and subcommittees where relevant; b) representation of the Service in clinical staff liaison meetings; c) involvement and provide regular input to the Senior Management Team.			
	EVIDENCE OF COMPLIANCE			
	1. Letter of representation/appointment of the Head of Service in committees and subcommittees where relevant, e.g. Procurement of Equipment Committee, Medical Records Committee, Hospital Infection and Antibiotic Control Committee, etc.			
	2. Minutes of meetings of committees			
	3. Minutes of meeting of Senior Management Team.			
	Facility Comments:			
17.1.1.7	The Head of the Rehabilitation Medicine Services shall be involved for the following aspects of management of the Rehabilitation Medicine Services: a) the preparation of budget and ensuring that expenditure remains within the budget allocated; b) human resource management and development; c) development of policies and procedures and ensuring compliance to them; d) facility and equipment management; e) safety and performance improvement activities and risk management.			
	EVIDENCE OF COMPLIANCE			
	1. Minutes of meetings of Rehabilitation Medicine Services indicate the involvement of Head of Service on aspects of items (a) to (e).			
	2. Attendance list of members with adequate quorum			
	3. Minutes are accessible to all staff			
	4. Endorsement of policies and procedures			
	5. Request for allocation of budget and staffing			
	6. Implementation of performance improvement activities			
	Facility Comments:			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17.1.1.8	Regular staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Rehabilitation Medicine Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.					
	EVIDENCE OF COMPLIANCE	1. Minutes are accessible, disseminated and acknowledged by the staff.				
		2. Attendance list of members with adequate representatives of the service.				
		3. Frequency of meetings as scheduled.				
		4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).				
	Facility Comments:					
17.1.1.9	Where there are medical practitioners in training, there is evidence that: a) their responsibilities for patient care are documented; b) their training needs are identified; c) appropriate supervision and training are given to the medical practitioners concerned.					
	EVIDENCE OF COMPLIANCE	1. Log books				
		2. Assessment reports				
		3. Training timetable, continuing medical education and attendances list.				
	Facility Comments:					
17.1.1.10	Appropriate statistics and records shall be maintained in relation to the provision of Rehabilitation Medicine Services and used for managing the services and patient care purposes.					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	EVIDENCE OF COMPLIANCE	1. Records are available but not limited to the following:				
		a) workload/census for inpatients and outpatients;				
		b) annual report;				
		c) accident/incident reports;				
		d) staffing number and staff profile;				
		e) staff training records;				
		f) data on performance improvement activities, including performance indicators.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 17.2		HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT				
STANDARD 17.2.1		The Rehabilitation Medicine Services shall be directed by a qualified and competent medical practitioner, and staffed by suitably qualified and competent clinical staff to achieve the goals and objectives of the Rehabilitation Medicine Services.				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17.2.1.1 CORE	There is documented evidence of appropriate training and competency for the granting of clinical privileging. The criteria for determining privileges are specified and documented. There is a structured process to ensure the stated criteria are uniformly applied to all applicants. These include: a) the criteria are designed to assure that patients will receive safe and quality care; b) the criteria for individual procedures are documented in detail, e.g. competency records/log books, application from the individual practitioner, recommendations from peer/referee and minutes of meeting; c) competency for each performance is dated, verified and signed by the supervisors; d) process for granting of clinical credentialing & privileging and re-privileging by authorized committee e) the period of time for which the privileges are to be granted is specified; f) current registration with the local professional registration bodies, e.g. Malaysian Medical Council, National Specialist Registry; g) peer recommendations are taken into account when privileges are being considered; h) the recommendations of the relevant department and/or major professional services for privileges to be granted are taken into consideration.					
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures are established to govern the credentialing and privileging processes which include items (a) to (g).				
		2. Compliance with policy and criteria for credentialing and privileging				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		3.	Competency records/log books			
		4.	Recommendations from peer/referee			
		5.	Privileging certificates, Annual Practising Certificate (APC) and National Specialist Register (NSR) Certificates			
		6.	Availability of the list of procedures requiring credentialing and privileging.			
		7.	Availability of list of procedures to include core procedures specific to the disciplines performed by medical officers.			
		8.	process of credentialing and privileging and re-privileging by authorised committee.			
	Facility Comments:					
17.2.1.2 CORE	Documented evidence of privileges conferred by the Governing Body is available and accessible to relevant staff at point of care.					
	EVIDENCE OF COMPLIANCE	1.	Formal letter of assignment or certificate of privileging with stipulated timeline are issued and reviewed accordingly.			
		2.	Updated list of staff with privileges conferred is made accessible at point of care.			
	Facility Comments:					
17.2.1.3	Clinical staff perform within the privileges conferred.					
	EVIDENCE OF COMPLIANCE	1.	Verification of procedures performed by individuals at point of care within the awarded privileging rights with evidence of:			
		a)	list of procedures privileged;			
		b)	clinical notes.			
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
17.2.1.4	There are written and dated job descriptions for all categories of staff that include: a) qualifications, training, experience and certification required for the position; b) lines of authority; c) accountability, functions, and responsibilities; d) reviewed when required and when there is a major change in any of the following: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations. e) administrative and clinical functions.			
	EVIDENCE OF COMPLIANCE			
	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e).			
	2. Job description shall include specialisation skills			
	3. Relevant privileges granted where applicable			
	4. The job description is acknowledged by the staff and signed the Head of Service and dated.			
	Facility Comments:			

SURVEY ITEM & SELF-ASSESSMENT								
STANDARD 17.2.2	STAFF TRAINING, EDUCATION, APPRAISAL AND RESEARCH The Facility and all staff shall demonstrate an ongoing commitment to continuing medical education.							
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
17.2.2.1	There are continuing education activities for staff including medical practitioners to pursue professional interests and to prepare for current and future changes in practice.							
	EVIDENCE OF COMPLIANCE	1. Training calendar includes in-house/external courses/ workshop/conferences						
		2. Contents of training programme						
		3. Training records on continuing education activities are kept and maintained for each staff including training in life support.						
		4. Certificate of attendance/degree/post basic training						
	Facility Comments:							
17.2.2.2	The educational needs of staff and the Facility, as evidenced by the results of medical-care evaluation such as incident reports, performance improvement studies and complaints, are taken into consideration when the content and structure of educational activities are planned.							
	EVIDENCE OF COMPLIANCE	1. Evidence of results of audit activities, e.g. mortality and morbidity reviews, incident reporting, etc in educational activities.						
		2. Evidence of improvement made and learning from corrective or preventive measures from incident reports.						
	Facility Comments:							
17.2.2.3	In a Facility where undergraduate medical, nursing and allied health training programmes are conducted, the Facility shall ensure that there are sufficient skilled trained staff to provide clinical supervision of students.							

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Sufficient skilled trained staff to provide clinical supervision as per terms of Memorandum of Understanding.				
	Facility Comments:					
17.2.2.4	There is evidence of training needs assessment and staff development plan which provides the knowledge and skills required for staff to maintain competency in their current positions and future advancement.					
	EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and gaps identified.				
		2. A staff development plan based on training needs assessment is available.				
		3. Training schedule/calendar is in place.				
		4. Training module				
	Facility Comments:					
17.2.2.5	Staff including medical practitioners receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.					
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff including medical practitioners is completed upon probationary period and as an annual exercise.				
	Facility Comments:					
17.2.2.6	Where appropriate the Facility shall endeavour to undertake clinical research using available resources.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Documented evidence of research activities e.g. protocol, policies, consent etc.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT				
STANDARD 17.2.3	STAFFING LEVEL AND STAFF COMPETENCY <i>The Head and staff of the Rehabilitation Medicine Services including medical practitioners are individuals qualified by education, training and experience commensurate with the requirements of the various positions and relevant laws.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
17.2.3.1	Deployment of all service providers for the Rehabilitation Medicine Services takes the following factors into consideration: a) the number of persons deployed is proportional to the number of patients being cared for as in good clinical practice, addressing also the intensity of care provided for; Rehabilitation Physician :1:16 patients Medical Officers :1:8 patients Nurses/Medical Assistants :1:4 patients (At least 1 post basic rehabilitation nurse available per shift) Physiotherapist :1:6 patients Occupational Therapists :1:6 patients Speech Therapists :1:6 patients Medical Social Worker :1:24 patients Clinical Psychologist :1:24 patients Healthcare Assistants :1:4 patients Clerks :1 per ward; 1 per clinic b) the categories of service providers based on qualifications and experience providing care reflect the complexity of clinical problems being managed; c) staffing needs shall take into consideration absences due to leave or sickness; double shift duties by clinical staff is documented and monitored; d) adequate staffing levels of appropriate competency shall be maintained throughout the hours the services are in operation. Where services need to be provided on a 24-hour basis, staffing level reflects the intensity of activities during each shift;			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	e) where it is not possible to have service providers on duty on site, e.g. after working hours, provision is made for relevant staff to be available on call; f) dietetic and pharmacy service providers are available on site.					
	EVIDENCE OF COMPLIANCE	1. Documentation and planning on deployment of staff that includes but not limited to items listed (a) to (f) with evidence of:				
		a) deployment based on staff to patient ratio, bed occupancy rate and complexity of cases;				
		b) special skills/training of staff;				
		c) contingency plan during acute shortage;				
		d) duty roster.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT											
STANDARD 17.2.4	STAFF ORIENTATION <i>A structured orientation programme introduces new staff to their services and to relevant aspects of the Facility to prepare them for their roles and responsibilities.</i>										
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS								
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING							
17.2.4.1	There is a structured orientation programme for all newly appointed staff to the Rehabilitation Medicine Services including medical practitioners and for those new to specific areas that include the following: a) explanation of the goals, objectives, policies and procedures of the Facility and those of the Rehabilitation Medicine Services; b) lines of authority and areas of responsibility; c) explanation of particular duties and functions; d) explanation of the methods of assigning clinical care and the standards of clinical practice; e) handover communication; f) processes for resolving practice dilemmas; g) information about safety procedures; h) training in basic/advanced life support techniques; i) methods of obtaining appropriate resource materials; j) staff appraisal procedures for the Rehabilitation Medicine Services; k) education on Patient and Family Rights; l) education on MSQH Standards requirements. m) grievance pathway for staff harassment.										
	<table><tr><td rowspan="3">EVIDENCE OF COMPLIANCE</td><td>1. Policy requiring all new staff to attend a structured orientation programme.</td><td></td></tr><tr><td>2. There is Rehabilitation Medicine Services orientation programme with relevant topics not limited to topics covered from (a) to (m).</td><td></td></tr><tr><td>3. Attendance list</td><td></td></tr></table>	EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme.		2. There is Rehabilitation Medicine Services orientation programme with relevant topics not limited to topics covered from (a) to (m).		3. Attendance list				
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	Facility Comments:										

SURVEY ITEM & SELF-ASSESSMENT						
<u>TOPIC 17.3:</u>		<u>POLICIES AND PROCEDURES</u>				
<u>STANDARD</u> <u>17.3.1</u>		<u>DEVELOPMENT, DERIVATION AND DOCUMENTATION</u> <i>There are written and dated policies and procedures for all activities of the Rehabilitation Medicine Services. These policies and procedures reflect current standards of medical practice, relevant statutory requirements, and the purposes of the services. These policies and procedures, terms of reference, by-laws, rules or regulations, state how the clinical staff including medical practitioners regulate themselves and provide patient care.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17.3.1.1 CORE	There are written policies and procedures for the Rehabilitation Medicine Services which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated.					
	There is a mechanism for and evidence of a periodic review at least once in every three years.					
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for the service.				
		2. Policies and procedures are consistent with regulatory requirements and current standard practices.				
		3. Evidence of periodic review of policies and procedures.				
		4. The policies and procedures are endorsed and dated.				
	Facility Comments:					
17.3.1.2	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved.					
	Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.				
		2. Minutes of meeting with evidence of cross reference with other departments				
		3. Documented cross departmental policies				
	Facility Comments:					
17.3.1.3 CORE	The policy and procedure documentation shall cover at least the following topics and any others required by law: a) description of the organisational structure of the Rehabilitation Medicine Services; b) clinical practice guidelines; c) clinical documentation includes pain as the 5 th vital sign where appropriate; d) handover communication; e) drug prescription, dispensing and administration; f) blood transfusion; g) continuing of care including regular review of patient, review of investigation results, discharge (planned or At Own Risk), referrals and escort as necessary; h) pain management; i) management of patients under police custody/prisoner; j) management of cases with infectious diseases including notification of notifiable diseases; k) the responsibilities of the staff including medical practitioners in relation to internal and external disasters are documented, and known to the staff (contingency plan); l) incident reports shall be compiled, investigated, discussed and recorded and action plans implemented; m) medical emergency, staff / patients safety as well as occupational safety and health are addressed; n) admission and discharge criteria is established; o) end of life care; p) management of a death.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures that address but not limited to items (a) to (p).				
		2. Incident reports and actions taken as required.				
		3. Policies on Code Blue, security response and Occupational Safety and Health Act with evidence of implementation process				
	Facility Comments:					
17.3.1.4	The care process shows documentary evidence of goal planning that involves team members, patients and care givers.					
	EVIDENCE OF COMPLIANCE	1. Samples of interdisciplinary records (IDR) documentation				
		2. Samples of family conferences documentation				
	Facility Comments:					
17.3.1.5	Care programmes incorporate the use of functional assessments at entry and completion of planned care programme.					
	EVIDENCE OF COMPLIANCE	1. Samples of IDR documentation				
		2. Samples of functional outcomes instrument used				
	Facility Comments:					
17.3.1.6	Care providers, where required, need to provide appropriate and adequate communication to subsequent healthcare providers taking over the patient's care.					
	EVIDENCE OF COMPLIANCE	1. Patient's medical records				
		2. Discharge summary/referral letter				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	Facility Comments:				
17.3.1.7	Evidence of facilitation of societal reintegration shall be available in the care process as shown by: a) assistive devices procurement; b) home assessment or visit documentation; c) community placement; d) school/ worksite assessment or visit documentation e) school/employment placement; f) return to work program / clinic; g) disability certification as per PWDs registration guidelines by Department for Development of PWDs.				
	EVIDENCE OF COMPLIANCE	1. Discharge summary			
		2. IDR documentation			
		3. Patient's clinical notes			
		4. Sample referral letter with evidence of (a) to (e)			
	Facility Comments:				
17.3.1.8	A programme shall be in place for the monitoring and continued training of patients and staff safety with regards to falls, transport/transfers and handling of patients.				
	EVIDENCE OF COMPLIANCE	1. Records on training for patients and staffs addressing:			
		a) falls;			
		b) transfer and handling of patients.			
	Facility Comments:				
17.3.1.9 CORE	A programme shall be in place for assessing, monitoring and measuring of improvement of inpatients undergoing active rehabilitation which includes the following:				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	a) conduct of interdisciplinary team meeting within one week of inpatient admission; b) the use of functional assessment measures within seven (7) days of patients undergoing inpatient rehabilitation; c) the use of functional assessment measures before cessation of rehabilitation programme for patients undergoing inpatient rehabilitation for at least seven (7) days; d) monitoring of patient and staff falls, occupational injuries and backache.					
	EVIDENCE OF COMPLIANCE	1. Structured programme for inpatients undergoing active rehabilitation that include the aspects of (a) to (d)				
		2. Discharge summary				
		3. IDR documentation and patient's clinical notes				
		4. Sample referral letter				
		5. Incident reports on falls, injuries etc of patients and staff				
		6. Sample of functional outcomes instrument used				
	Facility Comments:					
17.3.1.10	Current policies and procedures are communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings				
		2. Circulation list and acknowledgement				
	Facility Comments:					
17.3.1.11 CORE	There is evidence of compliance with policies and procedures.					
	EVIDENCE OF COMPLIANCE	1. Compliance with policies and procedures through:				
		a) interview of staff on practices;				
		b) verify with observation on practices;				
		c) results of audit on practices;				
		d) practices in line with established policies and procedures.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
17.3.1.12	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.					
	EVIDENCE OF COMPLIANCE	1. Copies of relevant policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.				
	Facility Comments:					
17.3.1.13	The services shall operate on a 24-hour basis providing a level of care appropriate to the activity of the patients in the Facility.					
	EVIDENCE OF COMPLIANCE	1. Operational policy on 24-hour services				
		2. Staffing level reflects good mix of experienced staff and the intensity of activities during each shift.				
		3. 24-hour duty roster				
		4. On-call roster is dated and authorised.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT							
TOPIC 17.4:		FACILITIES AND EQUIPMENT					
STANDARD 17.4.1		The Head of Rehabilitation Medicine Services shall ensure adequate facilities and equipment that are safe and appropriate are available for the staff to function effectively and to meet the goals and objectives of the Rehabilitation Medicine Services.					
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17.4.1.1	There are adequate and appropriate facilities and equipment with proper utilisation of space to enable staff to carry out their professional, teaching and administrative functions.						
	EVIDENCE OF COMPLIANCE	1. Adequate and proper utilisation of space.					
		2. Appropriate type of equipment to match the complexity of services.					
		3. Adequate facilities and equipment at each patient care area for safe care. (e.g. defibrillators, emergency cart, hand washing facilities etc)					
		4. Easy access and clear exit routes					
		5. Absence of overcrowding					
	Facility Comments:						
17.4.1.2	Existing facilities shall take cognizance of the safety of staff and patients.						
	EVIDENCE OF COMPLIANCE	1. Design and layout of the unit, e.g. wards, treatment rooms, dirty and clean utility rooms, access, lighting, signage, etc address the safety aspects of staff and patients.					
		2. Adequate equipment and supplies for Rehabilitation Medicine Services, e.g. emergency trolley, functioning patient call bell, adequate PPE etc.					
		3. Equipment should have scheduled planned preventive maintenance (PPM)					
	Facility Comments:						

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17.4.1.3	Suitable and adequate forms of communication and intercommunication systems and equipment are provided to enable clinical staff to communicate among themselves and with the other members of the healthcare team.					
	EVIDENCE OF COMPLIANCE	1. Appropriate and functioning telecommunication modalities available for daily operation and during emergencies e.g. landlines, hand phones, pagers, intercom.				
	Facility Comments:					
17.4.1.4	All medical devices procured after gazette ment of Medical Device Act 2012 shall comply with the regulations of the Acts.					
	EVIDENCE OF COMPLIANCE	1. Availability of relevant document and certificates				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT							
STANDARD 17.4.2	<i>FACILITIES AND EQUIPMENT FOR PATIENT CARE</i> <i>Adequate facilities and equipment shall be available to provide safe and effective patient care.</i>						
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17.4.2.1	Facilities are suitably located to facilitate easy access and to provide an atmosphere of user, environmental and ‘disabled’ friendly.						
	EVIDENCE OF COMPLIANCE	1. Floor plan indicates accessibility and patient and user friendly including disable friendly access environment					
		2. Feedback from patient satisfaction survey					
		3. Incident reporting relating to facilities if any.					
		4. Disabled friendly parking facilities					
	Facility Comments:						
17.4.2.2	Equipment, both for emergency and non-emergency usage, shall be appropriate to the level of care.						
	EVIDENCE OF COMPLIANCE	1. Availability of emergency and non-emergency equipment appropriate to level of care, such as defibrillator, emergency trolley, suction machine, electrocardiogram (ECG) machine, infusion or syringe pump, vital sign monitor, etc.					
		2. Scheduled checking of items in emergency trolley					
	Facility Comments:						
17.4.2.3 CORE	The wards where inpatient rehabilitation care is undertaken shall be equipped with the following:						
	a) beds are height adjustable, have removable cot sides, have single and/or double fowler position options with night light facility; b) nurse call system;						

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	c) pressure support system for care and protection of skin viability; d) disabled friendly toilets with hand railings and baths/showers that have thermostat safety control over piped hot water, nurse call system for assistance and safety devices for prevention of falls including mechanical lifting equipment; e) appropriate assistive devices for facilitating independent ability and basic activities of daily living shall be available. These include wheelchairs, commodes, walking aids amongst others. f) ceiling mounted or mobile hoist for safe transfer				
	EVIDENCE OF COMPLIANCE	1. Inpatient rehabilitation care facilities are appropriately equipped and include items listed (a) to (e).			
	Facility Comments:				
17.4.2.4	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.				
	EVIDENCE OF COMPLIANCE	1. Testing, commissioning and calibration records (certificates or stickers)			
		2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as evidence of compliance to the relevant standards and Acts.			
	Facility Comments:				
17.4.2.5 CORE	There is evidence that the facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.				
	EVIDENCE OF COMPLIANCE	1. Planned Preventive Maintenance records, such as schedule, stickers, etc.			
		2. Planned Replacement Programme where applicable			
		3. Complaint records			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	4. Asset inventory				
	Facility Comments:				
17.4.2.6	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.				
	EVIDENCE OF COMPLIANCE	1. User training records			
		2. Competency assessment record			
		3. Letter of authorisation			
		4. List of staff trained and authorised to operate specialised equipment			
	Facility Comments:				
17.4.2.7	Equipment is upgraded (based on evidence) from time to time so as to keep pace with advancement in operative and diagnostic techniques and technology.				
	EVIDENCE OF COMPLIANCE	1. Equipment are being replaced and upgraded to meet current standard of care in a planned and systematic manner.			
		2. Procurement of new technology where required is evidenced.			
	Facility Comments:				
17.4.2.8	The physical rehabilitation activity facilities include:				
	a) physiotherapy areas that incorporate adequate equipment and space for treatment, gait training, exercise and a heated hydrotherapy pool;				
	b) provision for disable accessible toilets, lockers and shower facilities that have thermostat safety control over piped hot water;				
	c) a general exercise area with flexible open space and at least one wall reinforced for installation of stall bars to be available;				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	d) availability of at least one (1) sink of sufficient width and depth for wet packs. Installation of ceiling moorings to support at least 230 kgs located at specific treatment areas for attachment of overhead equipment.					
	EVIDENCE OF COMPLIANCE	1. Design of the physical rehabilitation activity facilities meets the standard requirements and includes the aspects of (a) to (d).				
		2. Presence of the required equipment for the relevant rehabilitation activities.				
	Facility Comments:					
17.4.2.9	Occupational Therapy areas include space for upper limb function retraining, activities of daily living (ADL) training, work hardening, orthotic/pressure garment manufacture, cognition and perception training, pre-driving assessment, group activities and leisure activities.					
	EVIDENCE OF COMPLIANCE	1. Presence of the required facilities and equipment for occupational therapy activities.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT				
STANDARD 17.4.3	<i>FACILITIES FOR REHABILITATION MEDICINE OUTPATIENT SERVICES</i> <i>Where specialist outpatient services are provided, there are adequate outpatient clinics to enable the provision of safe and effective patient care, patient privacy and confidentiality.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
17.4.3.1	The Specialist Outpatient Services shall have the following features: a) the organisation and management of the clinics are planned so as to ensure prompt attention to patients, minimal waiting time, and avoidance of unnecessary visits by the patients; b) record keeping shall be efficient; c) an appointment or queuing system is used to manage patient consultations; d) the clinic is easily accessible including for non-ambulant patient and is easily identified through adequate signage. There should be provision for disabled friendly parking bays; e) the clinic is located close to other facilities, e.g. radiology, laboratories and pharmacy; f) appropriate assistive amenities and devices for facilitating independent ability and basic activities of daily living shall be available which include ramps, hand railings, wheelchairs, commodes, walking aids, single fowler height adjustable examination couches amongst others; g) disabled friendly toilets, hand railings and taps that have thermostat safety control over piped hot water, nurse call system for assistance and safety devices for prevention of falls; h) adequate provision is made for patient comfort; i) storage space, including adequate space for stretcher and wheelchair; j) child assessment and therapy and play area facilities for children; k) rooms/facilities for speech and clinical psychology assessment; l) resource centre for independent living equipment (preferably); m) independent living unit (preferable); n) sinks with hand washing facilities to be available in all treatment areas.			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	EVIDENCE OF COMPLIANCE	1. The Specialist Outpatient Services address (a) to (n) with evidence of but not limited to the following:				
		a) list of services available and offered to patients;				
		b) flow chart on work process;				
		c) safe keeping of medical records;				
		d) security of data in Health Information System;				
		e) clinic appointment system;				
		f) monitoring of waiting time;				
		g) adequate and appropriate signage;				
		h) adequate patient personal use items, e.g. wheelchair, etc;				
	i) adequate waiting area, rest rooms, refreshments, reading material and parking space.					
	Facility Comments:					
17.4.3.2	Adequate numbers of rooms are provided to ensure patient privacy and confidentiality for various patient care activities including: a) consultation (not more than one patient in a room at any time); b) conduct of minor procedures and nursing procedures; maintain a register of procedures performed; c) performance of various tests.					
	EVIDENCE OF COMPLIANCE	1. Adequate facilities for consultation and patient care activities that address (a) to (c) with evidence of but not limited to the following:				
		a) privacy of patient is ensured;				
		b) procedure room appropriately equipped;				
		c) patient monitoring device is available where required;				
	d) list of procedures done.					
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT					
TOPIC 17.5:		SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES			
STANDARD 17.5.1		The Head of Rehabilitation Medicine Services shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Rehabilitation Medicine Services. The Head of Rehabilitation Medicine Services shall ensure compliance to monitoring of specific performance indicators.			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
17.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Rehabilitation Medicine Services. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.				
	EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to (f)			
		2. Records on performance improvement activities			
		3. Minutes of performance improvement meetings			
		4. Performance improvement studies			
		5. Records on innovation if available.			
	Facility Comments:				
17.5.1.2	The Head of Rehabilitation Medicine Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement activities to appropriate individual/personnel within the respective services.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes of meetings				
		2. Letter of assignment of responsibilities				
		3. Job description				
	Facility Comments:					
17.5.1.3	The Head of the Rehabilitation Medicine Services shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility.					
	Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.					
	EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:				
		a) Training of staff				
		b) Policy on incident reporting				
		c) Methodology of incident reporting				
		d) Register/records of incidents				
		2. Completed incident reports				
		3. Root Cause Analysis				
		4. Corrective and preventive action plans				
		5. Remedial measure				
		6. Minutes of meetings				
		7. Acknowledgment by Head of Service and PIC/Hospital Director				
		8. Feedback given to staff regarding incident reporting.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
17.5.1.4 CORE	The staff including medical practitioners provide an appropriate peer group structure for performing the safety and performance improvement activities to accomplish clinical care evaluation.					
	a) The medical practitioners undertake clinical reviews of all risk assessments, incident reports, audits, safety and performance improvement activities: i) as a single committee for all safety and performance improvement activities; ii) in multidisciplinary committees within the Services; iii) in a variety of purpose-specific committees, such as mortality and morbidity, infection control, blood transfusion, etc.					
	b) Whatever structure is utilised, provision is made for review and analysis of the clinical work of each individual clinical service, department, unit or function.					
	c) Clinical audit assessment is undertaken at least one (1) annually.					
	EVIDENCE OF COMPLIANCE				1. Performance improvement activities	
	2. Minutes of meetings					
	3. Relevant reports and documents, e.g. clinical audit reports, incident reports, mortality and morbidity review reports, etc.					
	Facility Comments:					
17.5.1.5 CORE	There is tracking and trending of specific performance indicators not limited to but at least two (2) of the following: a) Percentage of patients with waiting time of ≤ 60 minutes to see the doctor at the Rehabilitation Medicine Outpatient Clinic (Two or more registration areas involved) b) Percentage of patients with waiting time of ≤ 90 minutes to see the doctor at the Rehabilitation Medicine Outpatient Clinic (Only one registration area involved) c) Percentage of patients with established interdisciplinary rehabilitation plan within ≤ 5 working days of admission					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	d) Percentage of falls and near-falls in Rehabilitation Medicine Outpatient Clinic					
	e) percentage of inpatients with functional measure assessment upon admission and prior to cessation of patient rehabilitation programme (Target: >90%)					
	EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored.				
		2. Records on tracking and trending analysis.				
		3. Remedial measures taken where appropriate				
	Facility Comments:					
17.5.1.6	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.					
	EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff.				
		2. Evidence of feedback via communication on results of performance improvement activities through continuing medical education/meetings.				
		3. Minutes of service/unit/committee meetings				
	Facility Comments:					
17.5.1.7	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.					
	EVIDENCE OF COMPLIANCE	1. Documentation on performance improvement activities and performance indicators.				
		2. Policy statement on anonymity on patients and providers involved in performance improvement activities.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT				
TOPIC 17.6:	<u>SPECIAL REQUIREMENTS</u>			
STANDARD 17.6.1	<u>SPINAL CORD INJURY</u> <i>The provision of Spinal Cord Injury Care shall be organised and provided as inpatient care services. The facility shall be equipped, operated and maintained in a manner that ensures patients are effectively cared for taking into consideration the safety of the patients, and staff in accordance to relevant regulatory requirements.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
17.6.1.1	<u>ORGANISATION OF SPINAL CORD INJURY CARE</u> The provision of Spinal Cord Injury Care shall be organised and managed through the following: a) a model of care of management is available; b) provision of Interdisciplinary Care involving Rehabilitation Medicine Physician, Nursing, Physiotherapy, Occupational Therapy, Medical Social Worker and Counsellors; c) consultation services from Urology, Plastic Surgery, Orthopaedics, Neurosurgery, Obstetrics and Gynaecology, Reproductive Medicine, Orthotic service is available or accessible; d) care plans are individualised, planned, monitored and evaluated; e) interdisciplinary records (IDR) and family conferences are an integral part of inpatient rehabilitation; f) patient assessment, functional and clinical status are measured at admission and upon discharge utilising at least the following : ASIA Neurological Assessment, Spinal Cord Independence Measure (SCIM), Modified Barthel Index (MBI); g) credentialing and privileging processes of the providers are established; h) allied Health staff must undergo at least three months of supervised work/training before undertaking unsupervised responsibilities; i) a registry of rehabilitated spinal cord injury patients will be maintained.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Evidence of availability of model of care document and compliance to the care plan instituted				
		2. Clinical and IDR documentation				
		3. Provision of information on accessibility of referral services				
		4. Evidence of relevant documents/ certifications				
		5. Evidence of registry of rehabilitated Spinal Cord Injury (SCI) patients				
	Facility Comments:					
17.6.1.2	<u>STAFFING REQUIREMENTS</u> a) The minimum number of staff for Level 4 Spinal Cord Injury Rehabilitation Service shall be as per rehabilitation standards except for: Rehabilitation Physician :1:16 patients Medical Officers :1:8 patients Nurses/Medical Assistants :1:4 patients (At least 1 post basic rehabilitation trained nurse available per shift) Physiotherapist :1:6 patients Occupational Therapists :1:6 patients Speech Therapists :1:16 patients Medical Social Worker :1:24 patients Clinical Psychologist :1:24 patients Healthcare Assistants :1:4 patients Clerks :1 per ward;1 per clinic b) The Rehabilitation Medicine Physician heading the Spinal Injury Care Rehabilitation team shall preferably have special interest / subspecialty training in Spinal Cord Injury Rehabilitation.					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	c) The therapist in the IDR team shall have undergone special interest training in Spinal Cord Injury rehabilitation of at least 3 months before undertaking unsupervised work. d) A case manager is available for each case.				
	EVIDENCE OF COMPLIANCE	1. Evidence of staff positions filled as per requirement 2. Certification of relevant training of Rehabilitation Medicine Physician/therapists and other staff where applicable 3. Evidence of a case manager for each case 4. IDR documentation 5. Patient's Clinical notes 6. Workload Census			
	Facility Comments:				
17.6.1.3	FACILITIES AND EQUIPMENT FOR SPINAL CORD INJURY (SCI) CARE There are adequate and appropriate facilities and equipment for provision of SCI care that include: a) preferably a Rehabilitation park for outdoor therapy; b) ward unit preferably be air conditioned; c) automated turning beds for pressure relief. d) hoist for safe transfer e) specialised wheelchairs – recliner, DAF, lightweight, motorized f) shower trolley or reclining commode wheelchair g) tilt table h) parallel bar i) various types of gait aids				
	EVIDENCE OF COMPLIANCE	1. Appropriate and adequate facilities and equipment that include (a) and (e).			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
17.6.1.4	<u>PERFORMANCE IMPROVEMENT</u> Performance improvement activities include the following: a) measurement of generic functional outcome measure at initial contact and prior to rehabilitation discharge – Modified Barthel Index (MBI); b) measurement of disease specific functional outcome measure at initial contact and prior to rehabilitation discharge - Spinal Cord Injury Independence Measure (SCIM)			
	EVIDENCE OF COMPLIANCE 1. Records on performance improvement that include (a) and (b) as evidenced upon inspection of:			
	a) IDR Documentation			
	b) Patient's Clinical Notes			
	Facility Comments:			

SURVEY ITEM & SELF-ASSESSMENT					
STANDARD 17.6.2		<u>STROKE</u> <i>The provision of Stroke Care shall be organised and provided as inpatient or outpatient care services. The facility shall be equipped, operated and maintained in a manner that ensures patients are effectively cared for taking into consideration the safety of the patients, and staff in accordance to relevant regulatory requirements.</i>			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
17.6.2.1	<u>ORGANISATION OF STROKE CARE</u> The provision of Stroke Care shall be organised and managed through the following: a) a model of care of management is available; b) functional and clinical measures incorporate at least the following: National Institute of Health Stroke Scale (NIHSS), Mini Mental State Examination (MMSE), Montreal Cognitive Assessment (MoCA), Modified Barthel Index (MBI), Motor Assessment Scale (MAS) Collaborative Dysphagia Audit (CODA)Guideline; c) consultation services from Neurologist, Neurosurgery, Geriatric, General Surgery, and Orthotic services are available or accessible; d) credentialing and privileging processes are established; e) a registry of rehabilitated stroke patients ~~will~~ shall be maintained.				
	EVIDENCE OF COMPLIANCE	1. Evidence of availability of model of care document and compliance to the care plan instituted.			
		2. Clinical and IDR documentation			
		3. Provision of information on accessibility of referral services			
		4. Evidence of relevant documents/certifications			
		5. Evidence of registry of rehabilitated stroke patients			
	Facility Comments:				
17.6.2.2	<u>STAFFING REQUIREMENTS</u> a) The minimum number of staff for a Level 4 Stroke Rehabilitation Services shall be as per rehabilitation standards.				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	b) The Rehabilitation Medicine Physician heading the Stroke Rehabilitation Team shall preferably have special interest / subspecialty training in Stroke Rehabilitation. c) The therapist in the IDR team shall have undergone special interest training in Stroke rehabilitation of at least three (3) months before undertaking unsupervised work. d) A case manager is available for each case. e) Allied health staff must undergo at least three (3) months of supervised work/training before undertaking unsupervised responsibilities.			
	EVIDENCE OF COMPLIANCE			
	1. Evidence of staff positions filled as per requirement			
	2. Certification of relevant training of Rehabilitation Medicine Physician/therapists and other staff where applicable.			
	3. Evidence of a case manager for each case			
	4. IDR documentation			
	5. Patient's Clinical notes			
	6. Workload Census			
	Facility Comments:			
17.6.2.3	<u>FACILITIES AND EQUIPMENT FOR STROKE REHABILITATION SERVICES</u> There are adequate and appropriate facilities and equipment for provision of Stroke Rehabilitation Services that include: a) Space and equipment that incorporate the following: i) Geriatric chairs with high back rest, arm and foot rest supports, and a table top. ii) Specialised wheelchair – recliner, DAF iii) Commode chair/wheelchair iv) Tilt table v) Parallel bar vi) Various types of gait aids vii) Hoist for safe transfer			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Appropriate and adequate facilities and equipment that include but not limited to (a).				
	Facility Comments:					
17.6.2.4	<u>PERFORMANCE IMPROVEMENT</u> Performance improvement activities include the following: a) Measurement of generic functional outcome measure at initial contact and upon rehabilitation discharge– Modified Barthel Index (MBI) b) Measurement of disease specific functional outcome measure at initial contact and upon rehabilitation discharge – Motor Assessment Scale (MAS)					
	EVIDENCE OF COMPLIANCE	1. Records on performance improvement that include (a) and (b) as evidenced upon inspection of:				
		a) IDR Documentation				
		b) Patient's Clinical Notes				
	Facility Comments:					

SERVICE SUMMARY	
SURVEYOR SUMMARY:	
OVERALL RATING:	
OVERALL RISK:	

SURVEY ITEM & SELF-ASSESSMENT											
SERVICE STANDARD 17A : ALLIED HEALTH PROFESSIONAL SERVICES – PHYSIOTHERAPY SERVICES											
	<u>PREAMBLE</u> <i>Physiotherapy Services form an integral part of rehabilitation services. Physiotherapists deal with human function and movement and help people to achieve their full physical potential and functional ability. They use physical approaches to promote, maintain and restore wellbeing throughout the lifespan. Assessments are the result of Clinical Reasoning resulting in identifying existing and potential problems leading to the most appropriate intervention strategy based on the best available evidence in order to deliver effective care. Physiotherapist may direct their intervention to specific population, e.g. Cardio-respiratory/Cardio-pulmonary, Neurological, and Musculoskeletal Rehabilitation in all age groups.</i> <i>These services are provided individually, institutionally, or in groups through social support systems.</i>										
<u>TOPIC</u> <u>17A.1:</u> <u>STANDARD</u> <u>17A.1.1</u>	<u>ORGANISATION AND MANAGEMENT</u> <i>The Physiotherapy Services shall be organised and administered to provide services to patients requiring restoration of physical and sensory disabilities and other related services in accordance with accepted standards of practices. In some instances, these services may be provided from external sources.</i>										
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS								
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING							
17A.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Physiotherapy Services are clearly documented and measurable that indicates safety, quality and patient centred care. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.										
	<table><tr><td rowspan="3">EVIDENCE OF COMPLIANCE</td><td>1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.</td><td></td></tr><tr><td>2. Goals and objectives of the Physiotherapy Services in line with the Facility statements are available, endorsed and dated.</td><td></td></tr><tr><td>3. Evidence of planned reviews of the above statements.</td><td></td></tr></table>	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.		2. Goals and objectives of the Physiotherapy Services in line with the Facility statements are available, endorsed and dated.		3. Evidence of planned reviews of the above statements.				
EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.										
	2. Goals and objectives of the Physiotherapy Services in line with the Facility statements are available, endorsed and dated.										
	3. Evidence of planned reviews of the above statements.										

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)				
		5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.				
	Facility Comments:					
17A.1.1.2 CORE	There is an organisation chart which: a) aprovides a clear representation of the structure, function and reporting relationships between Hospital Person In Charge (PIC), consultants, medical practitioners, Head of Physiotherapy Services and staff of the Physiotherapy Services; b) is accessible to all staff and clients; c) includes off-site services if applicable; d) is revised when there is a major change in any of the following: i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns.					
EVIDENCE OF COMPLIANCE	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), consultants, medical practitioners, Head of Physiotherapy Unit and staff of the Physiotherapy Services.					
	2. Organisation chart of the service is endorsed, dated and accessible.					
	3. At each unit level where applicable, an organisation chart is available, endorsed and dated that reflects the working relationships within the team.					
	4. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).					
Facility Comments:						

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17A.1.1.3	The Governing Body shall ensure that Physiotherapy Services are organised in such a way as to: a) facilitate the provision of physiotherapy services to patients in the Facility in a safe, efficient, effective and caring manner and with due regards for the needs, dignity and privacy of patients and confidentiality of their personal information; b) assure continuity of care; c) address the professional needs of staff; d) ensure the relevant staff are involved in the formulation of policies and procedures concerning patient care appropriate to the scope of services of the Facility.					
	EVIDENCE OF COMPLIANCE	1. The Physiotherapy Services is organised to cover activities but not limited to items (a) to (d) through:				
		a) work assignment schedule to ensure service provision;				
		b) staffing level and skill mix to provide the necessary service;				
		c) record on continuity of care in patient's medical treatment record;				
		d) Physiotherapy Standard Operating Procedures (SOP) and Code of Ethics made available, accessible and adhered to.				
		e) Professional Development Plan				
	Facility Comments:					
17A.1.1.4	Regular staff meetings are held between the Head of Physiotherapy Services and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Physiotherapy Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.					
	EVIDENCE OF COMPLIANCE	1. Minutes are accessible, disseminated and acknowledged by the staff.				
		2. Attendance list of members with adequate representatives of the service.				
		3. Frequency of meetings as scheduled.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).				
	Facility Comments:					
17A.1.1.5	The Head of Physiotherapy Services is involved in the planning, justification and management of the budget and resource utilisation of the services.					
	EVIDENCE OF COMPLIANCE	1. Minutes of Facility-wide management meeting				
		2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service.				
		3. Approved budget and resources.				
	Facility Comments:					
17A.1.1.6	The Head of Physiotherapy Services is involved in the appointment and/OR assignment of the staff.					
	EVIDENCE OF COMPLIANCE	1. Records on staff interview (if applicable)				
		2. Appointment/assignment letter of Head of Service				
		3. Job description of Head of Service				
		4. Records on staff deployment				
		5. Duty roster				
	Facility Comments:					
17A.1.1.7	Appropriate statistics and records shall be maintained in relation to the provision of Physiotherapy Services and used for managing the services and patient care purposes.					
	EVIDENCE OF COMPLIANCE	1. Records are available but not limited to the following:				
		a) workload/census;				
		b) annual report;				
		c) accident/incident reports;				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		d) staffing number and staff profile;				
		e) staff training records;				
		f) Data on performance improvement activities, including performance indicators.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
<u>TOPIC 17A.2</u>		<u>HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT</u>				
<u>STANDARD 17A.2.1</u>		<i>The Physiotherapy Services shall be directed and adequately staffed by qualified and experienced staff to achieve the goals and objectives of the services and ensure continuing education and professional development.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17A.2.1.1 CORE	The Head and staff of the Physiotherapy Services shall be individuals qualified by education, training, experience and certification to commensurate with the requirements of the various positions. All physiotherapists shall be registered following the requirements of the Allied Health Professions Act.					
	EVIDENCE OF COMPLIANCE	1. Records on credentials of Head of Service and staff required to fill up the posts within the service (to match the complexity of the Facility and services) and registration.				
		2. Appointment/assignment letters				
		3. Credentialing and privileging process are being followed to allow practice of specialised skills				
		4. Training and competency records				
	Facility Comments:					
17A.2.1.2	The authority, responsibilities and accountabilities of the Head of Physiotherapy Services are clearly delineated and documented.					
	EVIDENCE OF COMPLIANCE	1. Appointment/assignment letter for Head of Physiotherapy Services				
		2. Description of duties and responsibilities				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17A.2.1.3 CORE	Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the need of the services.				
	Relevant support staff shall work only under the supervision of a qualified physiotherapist.				
	EVIDENCE OF COMPLIANCE	1. Number of staff and qualification should commensurate with workload.			
		2. Appropriate skill mix of physiotherapists should be available to commensurate with the complexity of the services provided.			
		3. Staffing pattern			
		4. Duty roster			
		5. Census and statistics			
	Facility Comments:				
17A.2.1.4	There are written and dated specific job descriptions for all categories of staff that include:				
	a) qualifications, training, experience and certification required for the position; b) lines of authority; c) accountability, functions and responsibilities; d) reviewed when required and when there is a major change in any of the following: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required; v) staffing patterns; vi) Statutory Regulations. e) administrative and clinical functions.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e).				
		2. Job description includes specialisation skills				
		3. Relevant privileges granted where applicable				
		4. The job description is acknowledged by the staff and signed by the Head of Service and dated.				
	Facility Comments:					
17A.2.1.5	Personnel records on training, staff development, leave and others are maintained for every staff.					
	Note: <i>Staff personal record may be kept in Human Resource Department as per Facility policy.</i>					
	EVIDENCE OF COMPLIANCE	1. Staff personal records include:				
		a) staff biodata;				
		b) qualification and experience;				
		c) training record;				
		d) competency record and privileging;				
		e) leave record;				
		f) confidentiality agreement.				
	Facility Comments:					
17A.2.1.6	There is a structured orientation programme where new staff are briefed on their services operational policies and relevant aspects of the Facility to prepare them for their roles and responsibilities.					
	EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme.				
		2. Records on structured orientation programme				
		3. Orientation Brief				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	4. List of attendance				
	Facility Comments:				
17A.2.1.7	There is evidence of training needs assessment and staff development plan which provides the knowledge and skills required for staff to maintain competency in their current positions and future advancement.				
EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and gaps identified.				
	2. A staff development plan based on training needs assessment is available.				
	3. Training schedule/calendar is in place.				
	4. Training module				
	Facility Comments:				
17A.2.1.8	There are continuing education activities for staff to pursue professional interests and to prepare for current and future changes in practice.				
EVIDENCE OF COMPLIANCE	1. Continuing education activities and schedule				
	2. Contents of training programme				
	3. Training records on continuing education activities are kept and maintained for each staff.				
	4. Certificate of attendance/degree/post basic training.				
	Facility Comments:				
17A.2.1.9	Staff receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff is completed upon probationary period and as an annual exercise.				
	Facility Comments:					
17A.2.1.10	In a Facility where education programmes are conducted, the Facility shall ensure that there are sufficient skilled trained staff to provide clinical supervision of students.					
	EVIDENCE OF COMPLIANCE	1. Letter of appointment – Local Preceptor/Clinical Instructor.				
		2. Memorandum of Understanding with training institution				
		3. Adequate number of clinical instructor to students				
		4. Qualification and training records of local preceptor				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
<u>TOPIC</u> <u>17A.3:</u>	<u>POLICIES AND PROCEDURES</u>					
<u>STANDARD</u> <u>17A.3.1</u>	<i>There are written and dated policies and procedures for all activities of the Physiotherapy Services. These policies and procedures reflect current standards of Physiotherapy Services and practice, relevant regulations, statutory requirements, and the goals and objectives of the Physiotherapy Services.</i>					
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT		SURVEYOR RATING	
17A.3.1.1 CORE	There are written policies and procedures for the Physiotherapy Services which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated.					
	There is a mechanism for and evidence of a periodic review at least once in every three years.					
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for the service.				
		2. Policies and procedures are consistent with regulatory requirements and current standard practices.				
		3. Evidence of periodic review of policies and procedures.				
		4. The policies and procedures are endorsed and dated.				
Facility Comments:						
17A.3.1.2 CORE	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved which include: Patient Care:- a) care plan for each patient to achieve appropriate outcomes; b) prevention and control of infection practices where applicable; c) monitoring of the patient to assess the outcome of the care of patient; d) modifying the care when necessary;					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	e) completing the care; f) discharge care plan and follow up; g) cross-referral within team; h) referral guidelines i) communication – within and outside the Physiotherapy Services. Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.			
	1. Minutes of committee meetings on development and revision on policies and procedures.			
	2. Minutes of meeting with evidence of cross reference with other departments			
	3. Documented cross departmental policies			
	4. Policies, Procedures, Protocols, Manuals and Guidelines are customised to meet the relevant needs and level of services.			
	5. Policies and procedures on infection control practices (within the service).			
	6. Clinical documentation cover the following:			
	a) assessment leading to problem list and appropriate clinically reasoned Evidence Based Practice (EBP) plan of treatment;			
	b) evidence of reviewing outcomes of intervention;			
	c) evidence of modification of treatment plan (as necessary);			
	d) evidence of discharge/transfer plan;			
	e) documentation of transfer of care if applicable;			
	f) original referral forms.			
	7. Care plan and discharge plan including educational material provided for the patient.			
	Facility Comments:			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17A.3.1.3	There shall be a policy to address emergency resuscitation in the event of any life threatening situations and the Emergency Resuscitation Team can be alerted immediately, e.g. Code Blue.					
	EVIDENCE OF COMPLIANCE	1. Policy for Code Blue within the service area				
		2. Flow chart and contact number of Code Blue made available and accessible.				
	Facility Comments:					
17A.3.1.4	Current policies and procedures are communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings				
		2. Circulation list and acknowledgement				
	Facility Comments:					
17A.3.1.5 CORE	There is evidence of implementation and compliance with relevant policies and procedures through Risk Assessments prior to treatment					
	EVIDENCE OF COMPLIANCE	1. Compliance with policies and procedures through:				
		a) interview of staff on practices;				
		b) verify with observation on practices;				
		c) results of audit on practices, e.g. safe use of hot wax, electrical modalities, etc.				
		d) practices in line with established policies and procedures.				
		2. Documented Risk Assessments				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
17A.3.1.6	All outpatients seeking consultation/treatment to the Physiotherapy Services shall be referred by a medical practitioner.					
	EVIDENCE OF COMPLIANCE	1. Facility policy on referral to allied health services by medical practitioner				
		2. Referral letter/referral form written by medical practitioner				
		3. All patients/clients are registered in the manual register book or electronic system.				
		4. Patient's medical record				
	Facility Comments:					
17A.3.1.7	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible for staff reference.					
	EVIDENCE OF COMPLIANCE	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT				
TOPIC 17A.4:	<u>FACILITIES AND EQUIPMENT</u>			
STANDARD 17A.4.1	<i>Safe and adequate facilities and equipment are available for the delivery of effective physiotherapy services and ensuring patient safety.</i>			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT
				SURVEYOR RATING
17A.4.1.1	There is appropriate access to the facility, adequate facilities and equipment with proper utilisation of space to enable staff to carry out their professional, teaching and administrative functions.			
	EVIDENCE OF COMPLIANCE	1. Adequate and proper utilisation of space.		
		2. Appropriate type of equipment to match the complexity of services/modalities of care.		
		3. Adequate facilities and equipment at patient care area for safe care (e.g. access to emergency cart, hand washing facilities, etc).		
		4. Easy access and clear exit routes		
		5. Absence of overcrowding		
	Facility Comments:			
17A.4.1.2	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.			
	EVIDENCE OF COMPLIANCE	1. Testing, commissioning and calibration records. (certificates or stickers)		
		2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as evidence of compliance to the relevant standards and Acts.		
	Facility Comments:			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17A.4.1.3 CORE	There is evidence that the facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.					
	EVIDENCE OF COMPLIANCE	1. Planned Preventive Maintenance records such as schedule, stickers, etc.				
		2. Planned Replacement Programme where applicable				
		3. Complaint records				
		4. Asset inventory				
	Facility Comments:					
17A.4.1.4	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.					
	EVIDENCE OF COMPLIANCE	1. User training records				
		2. Competency record				
		3. Letter of authorisation				
		4. List of staff trained and authorised to operate specialised equipment				
	Facility Comments:					
17A.4.1.5 CORE	Disabled friendly toilets with call systems for assistance shall be made available.					
	EVIDENCE OF COMPLIANCE	1. Disabled friendly toilet with alarm bell/call system is available.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
17A.4.1.6	Alarm system for emergencies appropriate to client needs shall be made available.					
	EVIDENCE OF COMPLIANCE	1. Emergency alert alarm system, i.e. mechanical and Code Blue is in place.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT								
<u>TOPIC</u> <u>17A.5:</u>		<u>SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES</u>						
<u>STANDARD</u> <u>17A.5.1</u>		<i>The Head of Physiotherapy Services shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Physiotherapy Services.</i>						
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS					
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING				
17A.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Physiotherapy Services. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.							
	EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to (f)						
		2. Records on performance improvement activities						
		3. Minutes of performance improvement meetings						
		4. Performance improvement studies						
		5. Records on innovation if available						
	Facility Comments:							
17A.5.1.2	The Head of Physiotherapy Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement to appropriate individual/personnel within the respective services.							

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes of meetings				
		2. Letter of assignment of responsibilities				
		3. Job description				
	Facility Comments:					
17A.5.1.3	The Head of Physiotherapy Services shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility. Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.					
	EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:				
		a) Training of staff				
		b) Policy on incident reporting				
		c) Methodology of incident reporting				
		d) Register/records of incidents				
		2. Completed incident reports				
		3. Root Cause Analysis				
		4. Corrective and preventive action plans				
		5. Remedial measure				
		6. Minutes of meetings				
		7. Acknowledgment by Head of Service and PIC/Hospital Director				
		8. Feedback given to staff regarding incident reporting.				
	Facility Comments:					
17A.5.1.4 CORE	There is tracking and trending of specific performance indicators not limited to but at least two (2) of the following:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	a) incidence of burns sustained during delivery of electrotherapeutic modalities or thermal agents (sentinel event) b) Patient with musculoskeletal condition reported a reduction in pain scale (VAS) in each physiotherapy session (minimum of 3 sessions) within 2 months - target is 80% c) Percentage of inpatient referrals seen on time ($\leq$ 24 hours) by the physiotherapist (Target: 90%) d) Rate of positive outcomes from cases referred for chest physiotherapy by Intensive Care Unit e) Improvement in Modified Rivermead Mobility Index (MRMI) score within 6 months of physiotherapy intervention for newly referred Stroke patient					
	EVIDENCE OF COMPLIANCE				1. Specific performance indicators monitored.	
					2. Records on tracking and trending analysis.	
					3. Remedial measures taken where appropriate	
	Facility Comments:					
17A.5.1.5	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.					
EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff.					
	2. Evidence of feedback via communication on results of performance improvement activities through continuing education activities/meetings.					
	3. Minutes of service/unit meetings					
Facility Comments:						
17A.5.1.6	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Documentation on performance improvement activities and performance indicators.				
		2. Policy statement on anonymity on patients and providers involved in performance improvement activities.				
	Facility Comments:					

SERVICE SUMMARY	
SURVEYOR SUMMARY:	
OVERALL RATING:	
OVERALL RISK:	

SURVEY ITEM & SELF-ASSESSMENT				
SERVICE STANDARD 17B : ALLIED HEALTH PROFESSIONAL SERVICES – OCCUPATIONAL THERAPY SERVICES				
	<u>PREAMBLE</u> <i>Occupational therapy is a client-centred health profession concerned with promoting health and wellbeing through occupation. The primary goal is to enable people to participate in activities of everyday life. Occupational therapist achieves this outcome by working with people and communities to enhance their ability to engage in occupations they want to, need to and are expected to do, or by modifying the occupation or the environment to better support their occupational engagement.</i> <i>(World Federation of Occupational Therapists, WFOT 2012)</i> <i>These services are provided individually, institutionally, or in groups through social support systems.</i>			
<u>TOPIC</u> <u>17B.1:</u> <u>STANDARD</u> <u>17B.1.1</u>	<u>ORGANISATION AND MANAGEMENT</u> <i>The Occupational Therapy Services shall be organised and administered to meet the needs of the patient population being served in accordance with accepted standards of practices of the profession. In some instances, these services may be provided from sources external to the facility.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
17B.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Occupational Therapy Services are clearly documented and measurable that indicates safety, quality and patient centred care. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.					
		2. Goals and objectives of the Occupational Therapy Services in line with the Facility statements are available, endorsed and dated.					
		3. Evidence of planned reviews of the above statements.					
		4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)					
		5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.					
	Facility Comments:						
17B.1.1.2 CORE	There is an organisation chart which: a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head of Occupational Therapy Services, consultants, medical practitioners and staff of Occupational Therapy Services; b) is accessible to all staff and clients; c) includes off-site services if applicable; d) is revised when there is a major change in any of the following: i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns.						
	EVIDENCE OF COMPLIANCE	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head of Occupational Therapy Services, consultants, medical practitioners and staff of Occupational Therapy Services.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		2. Organisation chart of the service is endorsed, dated and accessible.				
		3. At each unit level where applicable, an organisation chart is available, endorsed and dated that reflects the working relationships within the team.				
		4. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).				
		Facility Comments:				
17B.1.1.3	The Governing Body shall ensure that Occupational Therapy Services are organised in such a way as to: a) facilitate the provision of occupational therapy services to patients in the Facility in a safe, efficient, effective and caring manner and with due regards for the needs, dignity and privacy of patients and confidentiality of their personal information; b) assure continuity of care; c) address the professional needs of staff; d) ensure the relevant staff are involved in the formulation of policies and procedures concerning patient care appropriate to the scope of services of the Facility.					
EVIDENCE OF COMPLIANCE	1. The Occupational Therapy Services is organised to cover activities but not limited to items (a) to (d) evidenced through:					
	a) work assignment schedule to ensure service provision;					
	b) staffing level and skill mix to provide the necessary service;					
	c) record on continuity of care in patient's medical treatment record;					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		d) Occupational Therapy Standard Operating Procedures (SOP) and Code of Ethics made available, accessible and adhered to;				
		e) Professional Development Plan.				
	Facility Comments:					
17B.1.1.4	Regular staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Occupational Therapy Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.					
	EVIDENCE OF COMPLIANCE	1. Minutes are accessible, disseminated and acknowledged by the staff.				
		2. Attendance list of members with adequate representatives of service.				
		3. Frequency of meetings as scheduled.				
		4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).				
	Facility Comments:					
17B.1.1.5	The Head of Occupational Therapy Services is involved in the planning, justification and management of the budget and resource utilisation of the services.					
	EVIDENCE OF COMPLIANCE	1. Minutes of Facility-wide management meeting				
		2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service.				
		3. Approved budget and resources.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17B.1.1.6	The Head of Occupational Therapy Services is involved in the appointment and/OR assignment of the staff.					
	EVIDENCE OF COMPLIANCE	1. Records on staff interview (if applicable)				
		2. Appointment/assignment letter of Head of Service				
		3. Job description of Head of Service				
		4. Records on staff deployment				
		5. Duty roster				
	Facility Comments:					
17B.1.1.7	Appropriate statistics and records shall be maintained in relation to the provision of Occupational Therapy Services and used for managing the services and patient care purposes.					
	EVIDENCE OF COMPLIANCE	1. Records are available but not limited to the following:				
		a) workload/census;				
		b) annual report;				
		c) accident/incident reports;				
		d) staffing number and staff profile;				
		e) staff training records;				
		f) data on performance improvement activities, including performance indicators				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
<u>TOPIC</u> <u>17B.2</u>	<u>HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT</u>					
<u>STANDARD</u> <u>17B.2.1</u>	<i>The Occupational Therapy Services shall be directed and adequately staffed by qualified and experienced staff to achieve the goals and objectives of the Occupational Therapy Services and ensure continuing education and development.</i>					
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
17B.2.1.1 CORE	The Head and staff of the Occupational Therapy Services shall be individuals qualified by education, training, experience and certification to commensurate with the requirements of the various positions. All occupational therapists shall be registered following the requirements of the Allied Health Professions Act.					
	EVIDENCE OF COMPLIANCE	1. Records on credentials of Head of Service and staff required to fill up the posts within the service (to match the complexity of the Facility and services) and registration.				
		2. Appointment/assignment letters				
		3. Certification				
		4. Training and competency records including privileging				
	Facility Comments:					
17B.2.1.2	The authority, responsibilities and accountabilities of the Head of Occupational Therapy Services are clearly delineated and documented.					
	EVIDENCE OF COMPLIANCE	1. Appointment/assignment letter for Head of Service.				
		2. Description of duties and responsibilities				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17B.2.1.3 CORE	Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the need of the services.				
	Relevant support staff shall work only under the supervision of a qualified occupational therapist.				
	EVIDENCE OF COMPLIANCE	1. Number of staff and qualification should commensurate with workload.			
		2. Appropriate skill mix of occupational therapists should be available to commensurate with the complexity of the services provided.			
		3. Staffing pattern			
		4. Duty roster			
		5. Census and statistics			
Facility Comments:					
17B.2.1.4	There are written and dated specific job descriptions for all categories of staff that include:				
	a) qualifications, training, experience and certification required for the position; b) lines of authority; c) accountability, functions and responsibilities; d) reviewed when required and when there is a major change in any of the following: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations. e) administrative and clinical functions.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e).				
		2. Job description includes specialisation skills				
		3. Relevant privileges granted where applicable				
		4. The job description is acknowledged by the staff and signed by the Head of Service and dated.				
	Facility Comments:					
17B.2.1.5	Personnel records on training, staff development, leave and others are maintained for every staff.					
	Note: Staff personal record may be kept in Human Resource Department as per Facility policy.					
	EVIDENCE OF COMPLIANCE	1. Staff personal records include:				
		a) staff biodata;				
		b) qualification and experience;				
		c) training record;				
		d) competency record and privileging;				
		e) leave record;				
		f) confidentiality agreement.				
	Facility Comments:					
17B.2.1.6	There is a structured orientation programme where new staff are briefed on their services, operational policies and relevant aspects of the Facility to prepare them for their roles and responsibilities.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme.				
		2. Records on structured orientation programme				
		3. Orientation Brief				
		4. List of attendance				
	Facility Comments:					
17B.2.1.7	There is evidence of training needs assessment and staff development plan which provides the knowledge and skills required for staff to maintain competency in their current positions and future advancement.					
	EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and gaps identified.				
		2. A staff development plan based on training needs assessment is available.				
		3. Training schedule/calendar is in place.				
		4. Training module				
	Facility Comments:					
17B.2.1.8	There are continuing education activities for staff to pursue professional interests and to prepare for current and future changes in practice.					
	EVIDENCE OF COMPLIANCE	1. Continuing education activities and schedule				
		2. Contents of training programme				
		3. Training records on continuing education activities are kept and maintained for each staff.				
		4. Certificate of attendance/degree/post basic training.				
	Facility Comments:					
17B.2.1.9	Staff receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff is completed upon probationary period and as an annual exercise.				
	Facility Comments:					
17B.2.1.10	In a Facility where education programs are conducted, the Facility shall ensure that there are sufficient skilled trained staff to provide clinical supervision of students.					
EVIDENCE OF COMPLIANCE	1. Letter of appointment – Local Preceptor/ Clinical Instructor.					
	2. Memorandum of Understanding with training institution					
	3. Adequate number of clinical instructor to students					
	4. Qualification and training records of local preceptor					
Facility Comments:						

SURVEY ITEM & SELF-ASSESSMENT						
<u>TOPIC</u> <u>17B.3:</u>		<u>POLICIES AND PROCEDURES</u>				
<u>STANDARD</u> <u>17B.3.1</u>		<i>There are written and dated policies and procedures for all activities of the Occupational Therapy Services. These policies and procedures reflect current standards of Occupational Therapy Services and practice, relevant regulations, statutory requirements, and the goals and objectives of the services.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17B.3.1.1 CORE	There are written policies and procedures for the Occupational Therapy Services which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated.					
	There is a mechanism for and evidence of a periodic review at least once in every three years.					
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for the service.				
		2. Policies and procedures are consistent with regulatory requirements and current standard practices.				
		3. Evidence of periodic review of policies and procedures.				
		4. The policies and procedures are endorsed and dated.				
Facility Comments:						
17B.3.1.2 CORE	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved which include:					
	Patient Care:- a) care plan for each patient to achieve appropriate outcomes; b) prevention and control of infection practices where applicable; c) monitoring of the patient to assess the outcome of the care of patient;					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	d) modifying the care when necessary; e) completing the care; f) discharge care plan and follow up; g) cross-referral within team; h) referral guidelines; i) communication – within and outside Occupational Therapy Services. Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.					
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.				
		2. Minutes of meeting with evidence of cross reference with other departments				
		3. Documented cross departmental policies				
		4. Policies, Procedures, Protocols, Manuals and Guidelines are customised to meet the relevant needs and level of services.				
		5. Policies and procedures on infection control practices (within the service).				
		6. Clinical documentation cover the following:				
		a) assessment leading to problem list and appropriate plan of treatment;				
		b) evidence of reviewing outcomes of intervention;				
		c) evidence of modification of treatment plan (as necessary);				
		d) evidence of discharge/transfer plan;				
		e) documentation of transfer of care;				
		f) original referral forms;				
		7. Care plan and discharge plan				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17B.3.1.3	There shall be a policy to address emergency resuscitation in the event of any life threatening situations and the Emergency Resuscitation Team can be alerted immediately, e.g. Code Blue.					
	EVIDENCE OF COMPLIANCE	1. Policy for Code Blue within the service area.				
		2. Flow chart and contact number of Code Blue made available and accessible.				
	Facility Comments:					
17B.3.1.4	Current policies and procedures are communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings				
		2. Circulation list and acknowledgement				
	Facility Comments:					
17B.3.1.5 CORE	There is evidence of implementation and compliance with relevant policies and procedures including the modalities of care provided by the occupational therapist.					
	EVIDENCE OF COMPLIANCE	1. Compliance with policies and procedures through:				
		a) record of care in patient's medical treatment record;				
		b) interview of staff on practices;				
		c) verify with observation on practices;				
		d) results of audit on practices;				
		e) practices in line with established policies and procedures.				
	Facility Comments:					
17B.3.1.6	All outpatients seeking consultation/treatment to the Occupational Therapy Services shall be referred by a medical practitioner.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Facility policy on referral to allied health services by medical practitioner				
		2. Referral letter/referral form written by medical practitioner				
		3. All patients/clients are registered in the manual register book or electronic system.				
		4. Patient's medical record				
	Facility Comments:					
17B.3.1.7	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.					
	EVIDENCE OF COMPLIANCE	1. Copies of related documents are accessible for staff reference as follows:				
		a)	Departmental and facility-wide policies and procedures			
		b)	Occupational Therapy Operational Management Plan (PPO)			
		c)	Occupational Therapy Standard Operating Procedure (SOP)			
		d)	Occupational Therapy Code Of Ethics And Professional Conduct			
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
<u>TOPIC</u> <u>17B.4:</u>	<u>FACILITIES AND EQUIPMENT</u>					
<u>STANDARD</u> <u>17B.4.1</u>	<i>Safe and adequate facilities and equipment are available for the delivery of effective Occupational Therapy Services and ensuring patient safety.</i>					
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17B.4.1.1	There is appropriate access to the facility, adequate facilities and equipment with proper utilisation of space to enable staff to carry out their professional, teaching and administrative functions.					
	EVIDENCE OF COMPLIANCE	1. Adequate and proper utilisation of space.				
		2. Appropriate type of equipment to match the complexity of services/modalities of care.				
		3. Adequate facilities and equipment at patient care area for safe care (e.g. access to emergency cart, hand washing facilities etc)				
		4. Easy access and clear exit routes				
		5. Absence of overcrowding				
	Facility Comments:					
17B.4.1.2	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.					
	EVIDENCE OF COMPLIANCE	1. Testing, commissioning and calibration records (certificates or stickers)				
		2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as evidence of compliance to the relevant standards and Acts.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17B.4.1.3 CORE	There is evidence that the facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.					
	EVIDENCE OF COMPLIANCE	1. Planned Preventive Maintenance records such as schedule, stickers, etc.				
		2. Planned Replacement Programme where applicable				
		3. Complaint records				
		4. Asset inventory				
	Facility Comments:					
17B.4.1.4	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.					
	EVIDENCE OF COMPLIANCE	1. User training records				
		2. Competency assessment record				
		3. Letter of authorisation				
		4. List of staff trained and competent to operate specialised equipment				
	Facility Comments:					
17B.4.1.5 CORE	Disabled friendly toilets with call systems for assistance shall be made available.					
	EVIDENCE OF COMPLIANCE	1. Disabled friendly toilet with alarm bell/call system is available.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
17B.4.1.6	Alarm system for emergencies appropriate to client needs shall be made available.				
	EVIDENCE OF COMPLIANCE	1. Emergency alert alarm system is available, i.e. mechanical and Code Blue is in place.			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT					
<u>TOPIC</u> <u>17B.5:</u>		<u>SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES</u>			
<u>STANDARD</u> <u>17B.5.1</u>		<i>The Head of Occupational Therapy Services shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Occupational Therapy Services.</i>			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
17B.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Occupational Therapy Services. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.				
EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to (f)				
	2. Records on performance improvement activities.				
	3. Minutes of performance improvement meetings				
	4. Performance improvement studies				
Facility Comments:					
17B.5.1.2	The Head of Occupational Therapy Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement to appropriate individual/personnel within the respective services.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	EVIDENCE OF COMPLIANCE	1. Minutes of meetings					
		2. Letter of assignment of responsibilities					
		3. Job description					
	Facility Comments:						
17B.5.1.3	The Head of Occupational Therapy Services shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility.						
	Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.						
	EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:					
		a) Training of staff					
		b) Policy on incident reporting					
		c) Methodology of incident reporting					
		d) Register/records of incidents					
		2. Completed incident reports					
		3. Root Cause Analysis					
		4. Corrective and preventive action plans					
		5. Remedial measure					
		6. Minutes of meetings					
		7. Acknowledgment by Head of Service and PIC/Hospital Director					
		8. Feedback given to staff regarding incident reporting.					
	Facility Comments:						

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
17B.5.1.4 CORE	There is tracking and trending of specific performance indicators at least two (2) of the following: a) Percentage of stroke patients with improvement of Activities of Daily Living (ADL) independence after 6 months of ADL interventions. (Target : > 75%) b) Percentage of patients with hand and upper limb injury who have attained a full score in prehension patterns within 3 months of Occupational Therapy interventions (Target : > 85%) c) Percentage of patients with developmental disabilities who improve in at least one component of development after 6 months of Occupational Therapy interventions. (Target: >80%)					
	EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored.				
		2. Records on tracking and trending analysis.				
		3. Remedial measures taken where appropriate				
	Facility Comments:					
17B.5.1.5	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.					
	EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff.				
		2. Evidence of feedback via communication on results of performance improvement activities through CME/meetings.				
		3. Minutes of service/unit meetings				
	Facility Comments:					
17B.5.1.6	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	EVIDENCE OF COMPLIANCE	1. Documentation on performance improvement activities and performance indicators.						
		2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						
	Facility Comments:							

SERVICE SUMMARY	
SURVEYOR SUMMARY:	
OVERALL RATING:	
OVERALL RISK:	

SURVEY ITEM & SELF-ASSESSMENT

SERVICE STANDARD 17C : ALLIED HEALTH PROFESSIONAL SERVICES - DIETETIC SERVICES

PREAMBLE

The Dietetic Services shall provide a high standard of medical nutrition therapy and wellness promotion to inpatients, outpatients and the community in a safe, efficient, effective and caring manner and shall be organised, directed and coordinated with other services in the Facility and community.

The scope of dietetic practice shall be provided by dietitians registered with the Malaysian Allied Health Professions Council (where applicable) and shall encompass the following:

- 1. Individualised patients' nutritional needs as prescribed.*
- 2. Documented Nutrition Care Process:*
 - a) Nutrition assessment*
 - b) Nutrition diagnosis*
 - c) Nutrition intervention*
 - d) Nutrition monitoring and evaluation*
- 3. Standards of professional performance:*
 - a) Provision of services – provides evidence based, safe and quality service to the patients.*
 - b) Communication and application of knowledge – effectively applies knowledge and communicates with others involved in the care of the patient.*
 - c) Application of research – effectively applies, participates in or generates research to enhance practice.*
 - d) Utilisation and management of resources – uses resources effectively and efficiently in practice.*
 - e) Quality in practice – systematically and continuously evaluates the safety, quality and effectiveness of practice and revises practice as needed to incorporate the results of evaluation.*
 - f) Continued competence and professional accountability – engages in lifelong self-development to improve knowledge and enhance professional competency.*

SURVEY ITEM &SELF-ASSESSMENT						
<u>TOPIC</u> <u>17C.1:</u>		<u>ORGANISATION AND MANAGEMENT</u>				
<u>STANDARD</u> <u>17C.1.1</u>		<i>The Dietetic Services shall be provided by dietitians registered with the Malaysian Allied Health Professions Council and shall encompass the provision of total nutritional care requirements of all patients, which includes individualised medical nutrition therapy, based on established standards of practice and professional performance. The services shall also promote wellness and increase awareness of the role of good nutrition in reducing the risk factors of chronic diseases. In some instances, these services may be provided by external sources.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17C.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Dietetic Services are clearly documented and measurable that indicates safety, quality and patient centred care. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.				
		2. Goals and objectives of the Dietetic Services in line with the Facility statements are available, endorsed and dated.				
		3. Evidence of planned reviews of the above statements.				
		4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)				
		5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.				
	Facility Comments:					
17C.1.1.2 CORE	There is an organisation chart which:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head of Dietetic Services, <u>consultants, medical practitioners</u> and staff of Dietetic Services; b) is accessible to all staff and clients; c) includes off-site services if applicable; d) is revised when there is a major change in any of the following: i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns.					
	EVIDENCE OF COMPLIANCE				1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head of Dietetic Services, <u>consultants, medical practitioners</u> and staff of the Dietetic Services.	
					2. Organisation chart of the service is endorsed, dated and accessible.	
					3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).	
	Facility Comments:					
17C.1.1.3 CORE	The dietitian who is the Head of the service shall be responsible for the Dietetic Services.					
	EVIDENCE OF COMPLIANCE	1. Job description of the Head of Dietetic Services				
		2. Monitoring reports on the service				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17C.1.1.4	The Governing Body shall ensure that Dietetic Services are organised in such a way as to:				
	a) facilitate the provision of dietetic services to patients in the Facility in a safe, efficient, effective and caring manner and with due regards for the needs, dignity and privacy of patients and confidentiality of their personal information;				
	b) assure continuity of care;				
	c) address the professional needs of staff;				
	d) ensure the relevant staff are involved in the formulation of policies and procedures concerning dietetic and nutrition care of the patient appropriate to the scope of services of the Facility.				
	EVIDENCE OF COMPLIANCE	1. The Dietetic Services is organised to cover activities but not limited to items (a) to (d) evidenced through:			
		a) work assignment schedule to ensure service provision;			
		b) number of dietitians commensurate with workload to provide the necessary service;			
		c) nutrition care note in the patient's medical record;			
		d) staff training records;			
e) minutes of meeting					
	f) operational policies and procedure.				
Facility Comments:					
17C.1.1.5	Regular staff meetings are held between the Head of Service and staff <u>with sufficient regularity</u> to discuss issues and matters pertaining to the operations of the Dietetic Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.				
	EVIDENCE OF COMPLIANCE	1. Minutes are accessible, disseminated and acknowledged by the staff.			
		2. Attendance list of members with adequate representatives of the service.			
		3. Frequency of meetings as scheduled.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	4.	Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).				
	Facility Comments:					
17C.1.1.6	The Head of Dietetic Services is involved in the planning, justification and management of the budget and resource utilisation for the various activities of the services.					
	EVIDENCE OF COMPLIANCE	1. Minutes of Facility-wide management meeting.				
		2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service.				
		3. Approved budget and resources.				
	Facility Comments:					
17C.1.1.7	The Head of Dietetic Services is involved in the appointment and/OR assignment of the staff.					
	EVIDENCE OF COMPLIANCE	1. Records on staff interview (if applicable)				
		2. Appointment/assignment letter of Head of Service				
		3. Job description of Head of Service				
		4. Records on staff deployment				
		5. Duty roster				
	Facility Comments:					
17C.1.1.8	Appropriate statistics and records shall be maintained in relation to the provision of Dietetic Services and used in managing the services and patient care purposes.					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Records are available but not limited to the following:			
		a) workload/census;			
		b) annual report;			
		c) accident/incident reports;			
		d) staffing number and staff profile;			
		e) staff training records;			
		f) data on performance improvement activities, including performance indicators.			
	Facility Comments:				
17C.1.1.9	Where Dietetic Services are provided by an external source, there is a written contract between the external service provider and the Facility stating the requirements for the services, including the following: a) formal lines of communication and responsibility between the external service provider and the Facility; b) personnel providing the services are certified dietitians; c) participation in appropriate committees; d) arrangements for after-hours and emergency services; e) involvement of the external service provider in safety and performance improvement activities of the Facility, as appropriate; f) space, facilities and equipment are provided by the organisation.				
EVIDENCE OF COMPLIANCE	1. Terms of Agreement include all items (a) to (f)				
	2. Compliance with the terms of the agreement evidenced on site.				
Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17C.1.1.10	Under the provision of cluster concept, where dietetic service is needed, an arrangement need to be set to esure the continuity of service is given including the following: (where applicable) a. Documentation b. Census Roster					
	EVIDENCE OF COMPLIANCE	Appropriate policy and procedure including items (a) to (c)				
		Compliance with policy and procedure.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
<u>TOPIC 17C.2:</u>		<u>HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT</u>				
<u>STANDARD 17C.2.1</u>		<i>The Dietetic Services shall be directed and adequately staffed by qualified and experienced staff to achieve the goals and objectives of the Dietetic Services. The dietitians shall be provided with continuous professional development to ensure competency and relevancy in their practice.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17C.2.1.1 CORE	The Head and staff of the Dietetic Services shall be individuals qualified by education, training, experience and certification to commensurate with the requirements of the various positions.					
	All dietitians shall be registered following the requirements of the Allied Health Professions Act.					
	EVIDENCE OF COMPLIANCE	1. Records on credentials of Head of Service and staff required to fill up the posts within the service (to match the complexity of the Facility and services) and registration.				
		2. Appointment/assignment letters				
		3. Certification				
		4. Training and competency records				
	Facility Comments:					
17C.2.1.2	The authority, responsibilities and accountabilities of the Head of Dietetic Services are clearly delineated and documented.					
	EVIDENCE OF COMPLIANCE	1. Appointment/assignment letter for Head of Service.				
		2. Description of duties and responsibilities				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
17C.2.1.3 CORE	Sufficient numbers of registered dietitians (where applicable) and support staff with appropriate qualifications are employed to meet the need of the services. Relevant support staff shall work only under the supervision of registered dietitians.				
EVIDENCE OF COMPLIANCE	1. Number of qualified staff and qualification should commensurate with workload.				
	2. Staffing pattern (Staff Assignment)				
	3. 2 Duty roster				
	4. 3. Census and statistics				
Facility Comments:					
17C.2.1.4	There are written and dated specific job descriptions for all categories of staff that include: a) qualifications, training, experience and certification required for the position; b) lines of authority; c) accountability, functions and responsibilities, d) reviewed when required and when there is a major change in any of the following: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations. e) administrative and clinical functions.				
EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e).				
	2. Job description includes specialisation skills.				
	3. The job description is acknowledged by the staff and signed by the Head of Service and dated.				
Facility Comments:					
17C.2.1.5	Personnel records on training, staff development, leave and others are maintained for every staff.				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	Note: Staff personal record may be kept in Human Resource Department as per Facility policy.				
	EVIDENCE OF COMPLIANCE	1. Staff personal records include:			
		a) staff biodata;			
		b) qualification and experience;			
		c) training record;			
		d) competency record and privileging;			
		e) leave record;			
		f) confidentiality agreement.			
	Facility Comments:				
17C.2.1.6	There is a structured orientation programme where new staff are briefed on their services, operational policies and relevant aspects of the Facility to prepare them for their roles and responsibilities.				
	EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme.			
		2. Records on structured orientation programme			
		3. Orientation Brief			
		4. List of attendance			
	Facility Comments:				
17C.2.1.7	There is evidence of training needs assessment and staff development plan which provides the knowledge and skills required for staff to maintain competency in their current positions and future advancement.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and gaps identified.				
		2. A staff development plan based on training needs assessment is available.				
		3. Training schedule/calendar is in place.				
		4. Training module				
	Facility Comments:					
17C.2.1.8	There are continuing education activities for staff to pursue professional interests and to prepare for current and future changes in practice.					
	EVIDENCE OF COMPLIANCE	1. Continuing education activities and schedule				
		2. Contents of training programme and records in specialised dietetic care, e.g. cardiac, renal, diabetes, paediatrics, intensive care, burns, cancer, nutrition support.				
		3. Training records on continuing education activities are kept and maintained for each staff.				
		4. Certificate of attendance/degree/post basic training.				
	Facility Comments:					
17C.2.1.9	Staff receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.					
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff is completed upon probationary period and as an annual exercise.				
	Facility Comments:					
17C.2.1.10	In a Facility where education programmes are conducted, the Facility shall ensure that there are sufficient skilled trained staff to provide clinical supervision of students.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Letter of appointment – Local Preceptor/ Clinical Instructor.				
		2. Memorandum of Understanding with training institution				
		3. Adequate number of clinical instructor to students - Dietitian : Student ratio (1:3-4)				
		4. Qualification and training records of local preceptor				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
<u>TOPIC 17C.3:</u>	<u>POLICIES AND PROCEDURES</u>					
<u>STANDARD 17C.3.1</u>	<i>There are written and dated policies and procedures for all activities of the Dietetic Services. These policies and procedures reflect current standards of dietetics services and practice, relevant regulations, statutory requirements, and the goals and objectives of the Dietetic Services.</i>					
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
17C.3.1.1 CORE	There are written policies and procedures for the Dietetic Services which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated. There is a mechanism for and evidence of a periodic review at least once in every three years.					
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for the service.				
		2. Policies and procedures are consistent with regulatory requirements and current standard practices.				
		3. Evidence of periodic review of policies and procedures.				
		4. The policies and procedures are endorsed and dated.				
	Facility Comments:					
17C.3.1.2	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved. Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.					
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.				
		2. Minutes of meeting with evidence of cross reference with other departments				
		3. Documented cross departmental policies				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17C.3.1.3	The dietary requirements of a patient shall be documented in a nutrition care plan which includes nutrition assessment, nutrition diagnosis, nutrition intervention, nutrition monitoring and evaluation in consultation with the medical practitioners and communicated to the nurses.					
	EVIDENCE OF COMPLIANCE	1. Nutrition Dietetic care notes in patient's medical records				
	Facility Comments:					
17C.3.1.4	There shall be a policy to address emergency resuscitation in the event of any life threatening situations and the Emergency Resuscitation Team can be alerted immediately, e.g. Code Blue.					
	EVIDENCE OF COMPLIANCE	1. Policy for Code Blue within the service area				
		2. Flow chart and contact number of Code Blue made available and accessible.				
	Facility Comments:					
17C.3.1.5	Current policies and procedures are communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings				
		2. Circulation list and acknowledgement				
	Facility Comments:					
17C.3.1.6 CORE	There is EVIDENCE OF COMPLIANCE with policies and procedures and standards of practice.					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Compliance with policies and procedures through: a) interview of staff on practices; b) verify with observation on practices; c) results of audit on practices; d) practices in line with established policies and procedures.			
	Facility Comments:				
17C.3.1.7	All outpatients seeking consultation/treatment to the Dietetic Services shall be referred by a medical practitioner.				
	EVIDENCE OF COMPLIANCE	1. Facility policy on referral to allied health services by medical practitioner 2. Referral letter/referral form written by medical practitioner 3. All patients/clients are registered in the manual register book or electronic system 4. Patient's medical records			
	Facility Comments:				
17C.3.1.8	Prescription of therapeutic diets , and enteral and parenteral feeding shall be performed by the dietitian in consultation with the referring medical practitioner.				
	EVIDENCE OF COMPLIANCE	1. Referral letter from referring medical practitioner. 2. Patient's medical records			
	Facility Comments:				
17C.3.1.9	A current diet manual is available to Dietitian.to the medical practitioners, food services staff and nursing staff. The diet manual shall include a description of diets provided by the services, including as reference for all therapeutic diets and those to suit religious and cultural preferences.				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Current Hospital diet manual			
	Facility Comments:				
17C.3.1.10	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.				
EVIDENCE OF COMPLIANCE	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site/workstation for staff reference.				
	2. Clinical Practice Guidelines				
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT							
TOPIC 17C.4:		<u>FACILITIES AND EQUIPMENT</u>					
STANDARD 17C.4.1		<i>Appropriate facilities and equipment shall be available for the efficient operation of the Dietetic Services.</i>					
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17C.4.1.1	There is appropriate access to the facility, adequate facilities and equipment with proper utilisation of space to enable staff to carry out their professional, teaching and administrative functions.						
	EVIDENCE OF COMPLIANCE	1. Adequate and proper utilisation of space.					
		2. Appropriate type of equipment to match the complexity of services- Assessment tools and education tools.					
		3. Easy access and clear exit routes					
	Facility Comments:						
17C.4.1.2	There shall be a room to ensure privacy and easily accessible to provide dietary consultation to the patients.						
	EVIDENCE OF COMPLIANCE	1. Dietitian's consultation room					
	Facility Comments:						
17C.4.1.3	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.						
	EVIDENCE OF COMPLIANCE	1. Testing, commissioning and calibration records (certificates or stickers)					
		2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as EVIDENCE OF COMPLIANCE to the relevant standards and Acts.					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	Facility Comments:				
17C.4.1.4	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.				
	EVIDENCE OF COMPLIANCE	1. User training records			
		2. Competency assessment record			
		3. Letter of authorisation			
		4. List of staff trained and authorised to operate specialised equipment			
	Facility Comments:				

SURVEY ITEM &SELF-ASSESSMENT						
<u>TOPIC 17C.5:</u>		<u>SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES</u>				
<u>STANDARD 17C.5.1</u>		<i>The Head of Dietetic Services shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Services.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17C.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Dietetic Services. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.					
	EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to (f)				
		2. Records on performance improvement activities.				
		3. Minutes of performance improvement meetings				
		4. Performance improvement studies				
		5. Records on innovation if available				
	Facility Comments:					
17C.5.1.2	The Head of Dietetic Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement to appropriate individual/personnel within the respective services.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes of meetings				
		2. Letter of assignment of responsibilities				
		3. Job description				
	Facility Comments:					
17C.5.1.3	The Head of the Dietetic Services shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility. Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.					
	EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:				
		a) Training of staff				
		b) Policy on incident reporting				
		c) Methodology of incident reporting				
		d) Register/records of incidents				
		2. Completed incident reports				
		3. Root Cause Analysis				
		4. Corrective and preventive action plans				
		5. Remedial measure				
		6. Minutes of meetings				
		7. Acknowledgment by Head of Service and PIC/Hospital Director				
		8. Feedback given to staff regarding incident reporting.				
	Facility Comments:					
17C.5.1.4 CORE	There is tracking and trending of specific performance indicators not limited to but at least two (2) of the following:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	a) percentage of inpatient referrals seen on time (≤ 24 hours) by the dietitian (Target: ≥ 85%) b) percentage of outpatient referrals seen by the dietitian within the stipulated time by the Dietetic Services and approved by the Facility (Target: ≥ 85%) c) Energy intake at least 70% of recommendation within 5 days of enteral nutrition initiation among patients in ward (Target: ≥ 80%)					
	EVIDENCE OF COMPLIANCE				1. Specific performance indicators monitored.	
					2. Records on tracking and trending analysis.	
					3. Remedial measures taken where appropriate	
	Facility Comments:					
17C.5.1.5	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.					
EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff.					
	2. Evidence of feedback via communication on results of performance improvement activities through continuing education activities/meetings.					
	3. Minutes of service/unit meetings					
Facility Comments:						
17C.5.1.6	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.					
EVIDENCE OF COMPLIANCE	1. Documentations on performance improvement activities and performance indicators.					
	2. Policy statement on anonymity on patients and providers involved in performance improvement activities.					
Facility Comments:						

SERVICE SUMMARY	
SURVEYOR SUMMARY:	
OVERALL RATING:	
OVERALL RISK:	

SURVEY ITEM & SELF-ASSESSMENT				
SERVICE STANDARD 17D : ALLIED HEALTH PROFESSIONAL SERVICES – SPEECH – LANGUAGE THERAPY SERVICES				
	<u>PREAMBLE</u> <i>Speech-Language Therapy Services form an integral part of rehabilitation services. Specific speech-language therapy services address normal and disorders in the following areas: language (comprehension and expression), speech sound production, resonance, voice, fluency and swallowing. These activities are conducted in a manner that take into consideration the impact of culture and linguistic exposure/ acquisition and uses the best available evidence for practice to ensure optimum outcomes for persons with language, voice, speech, sound, fluency, communication and swallowing disorders or differences.</i> <i>The practice encompasses clinical services of screening, assessment/ evaluation, diagnosis, treatment, intervention, consultation, prevention, education, collaboration, documentation and referral to the relevant services.</i> <i>These services are provided individually, institutionally, or in groups through social support systems.</i>			
<u>TOPIC 17D.1:</u> <u>STANDARD</u> <u>17D.1.1</u>	<u>ORGANISATION AND MANAGEMENT</u> <i>The Speech-Language Therapy Services shall be organised and administered to meet the needs of the patient population being served in accordance with accepted standards of practices of the profession. In some instances these services may be provided from sources external to the Facility.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
17D.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Speech-Language Therapy Services are clearly documented and measurable that indicates safety, quality and patient centred care. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS				
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING			
	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.							
		2. Goals and objectives of the Speech-Language Therapy Services in line with the Facility statements are available, endorsed and dated.							
		3. Evidence of planned reviews of the above statements.							
		4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)							
		5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.							
	Facility Comments:								
17D.1.1.2 CORE	There is an organisation chart which: a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head of Speech-Language Therapy Services, consultants, medical practitioners and staff of Speech-Language Therapy Services; b) is accessible to all staff and clients; c) includes off-site services if applicable; d) is revised when there is a major change in any of the following: i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns.								
	EVIDENCE OF COMPLIANCE	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head of Speech-Language Therapy Services, consultants, medical practitioners and staff of Speech-Language Therapy Services.							
		2. Organisation chart of the service is endorsed, dated and accessible.							
		3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).							

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS														
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING													
	Facility Comments:																
17D.1.1.3	The Governing Body shall ensure that Speech-Language Therapy Services are organised in such a way as to: a) facilitate the provision of speech-language therapy services to patients in the Facility in a safe, efficient, effective and caring manner and with due regards for the needs, dignity and privacy of patients and confidentiality of their personal information; b) assure continuity of care; c) address the professional needs of speech-language therapy staff; d) ensure the relevant staff are involved in the formulation of policies and procedures concerning speech and language care appropriate to the scope of services of the Facility.																
	<table><tr><td rowspan="6">EVIDENCE OF COMPLIANCE</td><td>1. The Speech – Language Therapy Services is organised to cover activities but not limited to items (a) to (d) through:</td><td></td></tr><tr><td>a) work assignment schedule to ensure service provision;</td><td></td></tr><tr><td>b) competent staffing level to provide the necessary</td><td></td></tr><tr><td>c) privileging for extended clinical role, if any;</td><td></td></tr><tr><td>d) record on continuity of care in patient's medical treatment record;</td><td></td></tr><tr><td>e) Professional Development Plan.</td><td></td></tr></table>	EVIDENCE OF COMPLIANCE	1. The Speech – Language Therapy Services is organised to cover activities but not limited to items (a) to (d) through:		a) work assignment schedule to ensure service provision;		b) competent staffing level to provide the necessary		c) privileging for extended clinical role, if any;		d) record on continuity of care in patient's medical treatment record;		e) Professional Development Plan.				
EVIDENCE OF COMPLIANCE	1. The Speech – Language Therapy Services is organised to cover activities but not limited to items (a) to (d) through:																
	a) work assignment schedule to ensure service provision;																
	b) competent staffing level to provide the necessary																
	c) privileging for extended clinical role, if any;																
	d) record on continuity of care in patient's medical treatment record;																
	e) Professional Development Plan.																
	Facility Comments:																
17D.1.1.4	Regular staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Speech-Language Therapy Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.																
	<table><tr><td rowspan="3">EVIDENCE OF COMPLIANCE</td><td>1. Minutes are accessible, disseminated and acknowledged by the staff.</td><td></td></tr><tr><td>2. Attendance list of members with adequate representatives of the service.</td><td></td></tr><tr><td>3. Frequency of meetings as scheduled.</td><td></td></tr></table>	EVIDENCE OF COMPLIANCE	1. Minutes are accessible, disseminated and acknowledged by the staff.		2. Attendance list of members with adequate representatives of the service.		3. Frequency of meetings as scheduled.										
EVIDENCE OF COMPLIANCE	1. Minutes are accessible, disseminated and acknowledged by the staff.																
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	3. Frequency of meetings as scheduled.																

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).				
		Facility Comments:				
17D.1.1.5		The Head of Speech-Language Therapy Services is involved in the planning, justification and management of the budget and resource utilisation of the services.				
	EVIDENCE OF COMPLIANCE	1. Minutes of Facility-wide management meeting				
		2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service.				
		3. Approved budget and resources.				
		Facility Comments:				
17D.1.1.6		The Head of Speech-Language Therapy Services is involved in the appointment and/OR assignment of the staff.				
	EVIDENCE OF COMPLIANCE	1. Records on staff interview (if applicable)				
		2. Appointment/assignment letter of Head of Service				
		3. Job description of Head of Service				
		4. Records on staff deployment				
		4. Duty roster				
		Facility Comments:				
17D.1.1.7		Appropriate statistics and records shall be maintained in relation to the provision of Speech-Language Therapy Services and used for managing the services and patient care purposes.				
	EVIDENCE OF COMPLIANCE	1. Records are available but not limited to the following:				
		a) workload/census;				
		b) annual report;				
		c) accident/incident reports				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		d) staffing number and staff profile;				
		e) staff training records;				
		f) data on performance improvement activities, including performance indicators.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT							
TOPIC 17D.2:		HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT					
STANDARD 17D.2.1		Speech-Language Therapy Services shall be directed and adequately staffed by qualified and experienced staff to achieve the goals and objectives of the Speech-Language Therapy Services, and ensure continuing education and development.					
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS			
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
17D.2.1.1 CORE	The Head and staff of the Speech-Language Therapy Services shall be individuals qualified by education, training, experience and certification to commensurate with the requirements of the various positions.						
	All speech-language therapists shall be registered following the requirements of the Allied Health Professions Act						
	EVIDENCE OF COMPLIANCE	1. Records on credentials of Head of Service and staff required to fill up the posts within the service (to match the complexity of the Facility and services) and registration.					
		2. Appointment/assignment letters					
		3. Certification					
		4. Training and competency records including privileging					
	Facility Comments:						
17D.2.1.2	The authority, responsibilities and accountabilities of the Head of Speech-Language Therapy Services are clearly delineated and documented.						
	EVIDENCE OF COMPLIANCE	1. Appointment/assignment letter for Head of Service.					
		2. Description of duties and responsibilities					
	Facility Comments:						

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17D.2.1.3 CORE	Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the need of the services. Relevant support staff shall work only under supervision of a qualified speech-language therapist.				
	EVIDENCE OF COMPLIANCE	1. Number of staff and qualification should commensurate with workload.			
		2. Current Practising Certificate.			
		3. Staffing pattern			
		4. Duty roster			
		5. Census and statistics			
	Facility Comments:				
17D.2.1.4	There are written and dated specific job descriptions for all categories of staff that include: a) qualifications, training, experience and certification required for the position; b) lines of authority; c) accountability, functions and responsibilities, d) reviewed when required and when there is a major change in any of the following: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations. e) administrative and clinical functions				
	EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e).			
		2. Job description includes specialisation skills			
		3. Relevant privileges granted where applicable			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	4. The job description is acknowledged by the staff and signed by the Head of Service and dated.					
	Facility Comments:					
17D.2.1.5	Personnel records on training, staff development, leave and others are maintained for every staff. Note: Staff personal record may be kept in Human Resource Department as per Facility policy.					
	EVIDENCE OF COMPLIANCE	1. Staff personal records include:				
		a) staff biodata;				
		b) qualification and experience;				
		c) training record;				
		d) competency record and privileging;				
		e) leave record;				
		f) confidentiality agreement.				
	Facility Comments:					
17D.2.1.6	There is a structured orientation programme where new staff are briefed on their services operational policies and relevant aspects of the Facility to prepare them for their roles and responsibilities.					
	EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme.				
		2. Records on structured orientation programme				
		3. Orientation Brief				
		4. List of attendance				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17D.2.1.7	There is evidence of training needs assessment and staff development plan which provides the knowledge and skills required for staff to maintain competency in their current positions and future advancement.					
	EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and gaps identified.				
		2. A staff development plan based on training needs assessment is available.				
		3. Training schedule/calendar is in place.				
		4. Training module				
	Facility Comments:					
17D.2.1.8	There are continuing education activities for staff to pursue professional interests and to prepare for current and future changes in practice.					
	EVIDENCE OF COMPLIANCE	1. Continuing education activities and schedule				
		2. Contents of training programme				
		3. Training records on continuing education activities are kept and maintained for each staff.				
		4. Certificate of attendance/degree/post basic training.				
	Facility Comments:					
17D.2.1.9	Staff receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.					
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff is completed upon probationary period and as an annual exercise.				
	Facility Comments:					
17D.2.1.10	In a Facility where education programmes are conducted, the Facility shall ensure that there are sufficient skilled trained staff to provide clinical supervision of students.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	EVIDENCE OF COMPLIANCE	1. Letter of appointment – Local Preceptor/ Clinical Instructor.					
		2. Memorandum of Understanding with training institution					
		3. Adequate number of clinical instructor to students					
		4. Qualification and training records of local preceptor					
	Facility Comments:						

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 17D.3: POLICIES AND PROCEDURES STANDARD 17D.3.1 <i>There are written and dated policies and procedures for all activities of the Speech-Language Therapy Services. These policies and procedures reflect current standards of speech-language therapy services and practice, relevant regulations, statutory requirements and the goals and objectives of the Speech-Language Therapy Services.</i>						
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17D.3.1.1 CORE	There are written policies and procedures for the Speech-Language Therapy Services which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated. There is a mechanism for and evidence of a periodic review at least once in every three years.					
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for the service. This shall include, but not limited to:				
		a) source of referral;				
		b) clinical management guidelines;				
		c) discharge care plan;				
		d) prevention and control of infection;				
		e) referral guidelines.				
		2. Policies and procedures are consistent with regulatory requirements and current standard practices.				
		3. Evidence of periodic review of policies and procedures.				
	4. The policies and procedures are endorsed and dated.					
Facility Comments:						

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17D.3.1.2 CORE	Policies and procedures are developed in collaboration with staff and where appropriate with other external services which include: a) care plan for each patient to achieve appropriate outcomes; b) monitoring of the patient to assess the outcome of the care; c) modifying the care when necessary; d) completing the care; e) discharge care plan and follow up; f) cross-referral within team; g) referral guidelines; h) communication – within and outside the Speech-Language Therapy Services. Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.				
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.			
		2. Minutes of meeting with evidence of cross reference with other departments			
		3. Documented cross departmental policies			
		4. Policies, Procedures, Protocols, Manuals and Guidelines are customised to meet the relevant needs and level of services.			
		5. Clinical documentation cover the following:			
		a) assessment leading to problem list and appropriate plan of treatment;			
		b) evidence of reviewing outcomes of intervention;			
		c) evidence of modification of treatment plan (as necessary);			
		d) evidence of discharge/transfer plan;			
		e) documentation of transfer of care;			
		f) original referral forms.			
		6. Care plan and discharge plan			
		Facility Comments:			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17D.3.1.3	There shall be a policy to address emergency resuscitation in the event of any life threatening situations and the Emergency Resuscitation Team can be alerted immediately, e.g. Code Blue.					
	EVIDENCE OF COMPLIANCE	1. Policy for Code Blue within the service area				
		2.Flow chart and contact number of Code Blue made available and accessible.				
	Facility Comments:					
17D.3.1.4	Current policies and procedures are communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings				
		2. Circulation list and acknowledgement				
	Facility Comments:					
17D.3.1.5 CORE	There is evidence of compliance with relevant policies and procedures and standards of practice.					
	EVIDENCE OF COMPLIANCE	1. Compliance with policies and procedures through:				
		a) record of care in patient's medical treatment record;				
		b) interview of staff on practices;				
		c) verify with observation on practices;				
		d) practices in line with established policies and procedures.				
		e) compliance records and /or compliance audit reports				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
17D.3.1.6	All outpatients seeking consultation/treatment to the Speech-Language Therapy Services shall be referred by a medical practitioner.					
	EVIDENCE OF COMPLIANCE	1. Facility policy on referral to allied health services by medical practitioner				
		2. Referral letter/referral form written by medical practitioner				
		3. All patients/clients are registered in the manual register book or electronic system.				
		4. Patient's medical records				
	Facility Comments:					
17D.3.1.7	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.					
	EVIDENCE OF COMPLIANCE	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT								
TOPIC 17D.4:		<u>FACILITIES AND EQUIPMENT</u>						
<u>STANDARD</u> <u>17D.4.1</u>		<i>Safe and adequate facilities and equipment are available for the delivery of effective Speech-Language Therapy Services and ensuring patient safety.</i>						
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS				
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING			
17D.4.1.1	There is appropriate access to the facility, adequate facilities and equipment with proper utilisation of space to enable staff to carry out their professional, teaching and administrative functions.							
	EVIDENCE OF COMPLIANCE	1. Adequate and proper utilisation of space.						
		2. Appropriate type of equipment to match the complexity of services/modalities of care.						
		3. Adequate facilities and equipment at patient care area for safe care (e.g. access to emergency cart, hand washing facilities, etc).						
		4. Easy access and clear exit routes						
		5. Absence of overcrowding						
	Facility Comments:							
17D.4.1.2	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.							
	EVIDENCE OF COMPLIANCE	1. Testing, commissioning and calibration records (certificates or stickers)						
		2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as EVIDENCE OF COMPLIANCE to the relevant standards and Acts.						
	Facility Comments:							

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17D.4.1.3 CORE	There is evidence that the facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.					
	EVIDENCE OF COMPLIANCE	1. Planned Preventive Maintenance records such as schedule, stickers, etc.				
		2. Planned Replacement Programme where applicable				
		3. Complaint records				
		4. Asset inventory				
	Facility Comments:					
17D.4.1.4	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.					
	EVIDENCE OF COMPLIANCE	1. User training records				
		2. Competency assessment record				
		3. Letter of authorisation				
		4. List of staff trained and authorised to operate specialised equipment				
	Facility Comments:					
17D.4.1.5	Alarm system for emergencies appropriate to client needs shall be made available.					
	EVIDENCE OF COMPLIANCE	1. Emergency alert alarm system is available, i.e. mechanical and Code Blue is in place.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT															
TOPIC 17D.5: SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES															
STANDARD 17D.5.1 <i>The Head of Speech-Language Therapy Services shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Speech-Language Therapy Services.</i>															
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS												
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING											
17D.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Speech-Language Therapy Services. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated. <table border="1"> <tr> <td rowspan="5">EVIDENCE OF COMPLIANCE</td> <td>1. Planned performance improvement activities include (a) to</td> <td></td> </tr> <tr> <td>2. Records on performance improvement activities.</td> <td></td> </tr> <tr> <td>3. Minutes of performance improvement meetings</td> <td></td> </tr> <tr> <td>4. Performance improvement studies</td> <td></td> </tr> <tr> <td>5. Records on innovation if available</td> <td></td> </tr> </table> Facility Comments:	EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to		2. Records on performance improvement activities.		3. Minutes of performance improvement meetings		4. Performance improvement studies		5. Records on innovation if available				
EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to														
	2. Records on performance improvement activities.														
	3. Minutes of performance improvement meetings														
	4. Performance improvement studies														
	5. Records on innovation if available														
17D.5.1.2	The Head of Speech-Language Therapy Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement to appropriate individual/personnel within the respective services.														

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes of meetings				
		2. Letter of assignment of responsibilities				
		3. Job description				
	Facility Comments:					
17D.5.1.3	The Head of the Speech-Language Therapy Services shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility. Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.					
	EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:				
		a) Training of staff				
		b) Policy on incident reporting				
		c) Methodology of incident reporting				
		d) Register/records of incidents				
		2. Completed incident reports				
		3. Root Cause Analysis				
		4. Corrective and preventive action plans				
		5. Remedial measure				
		6. Minutes of meetings				
		7. Acknowledgment by Head of Service and PIC/Hospital Director				
		8. Feedback given to staff regarding incident reporting.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
17D.5.1.4 CORE	There is tracking and trending of specific performance indicators not limited to but at least two (2) of the following:					
	a) percentage of new cases outpatient referrals given appointment within 90 days (waiting time between the date patient presents to request for appointment and the initial appointment given within 90 days). (Target: ≥85%)					
	b) percentage of inpatient referrals of swallowing and feeding difficulties responded within 3 working days. (Target: ≥85%)					
	c) percentage of patient satisfaction towards patient education in therapy (Target: ≥80%)					
	EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored.				
		2. Records on tracking and trending analysis.				
3. Remedial measures taken where appropriate.						
Facility Comments:						
17D.5.1.5	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.					
	EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible in the service/unit				
		2. Evidence of feedback via communication on results of performance improvement activities through continuing education activities/meetings.				
		3. Minutes of service/unit meetings				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
17D.5.1.6	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.					
	EVIDENCE OF COMPLIANCE	1. Documentation on performance improvement activities and performance indicators.				
		2. Policy statement on anonymity on patients and providers involved in performance improvement activities.				
	Facility Comments:					

SURVEYOR SUMMARY:

OVERALL RISK:

SURVEY ITEM & SELF-ASSESSMENT					
SERVICE STANDARD 17E : ALLIED HEALTH PROFESSIONAL SERVICES - AUDIOLOGY SERVICES					
	PREAMBLE <i>Audiology Services are provided by Audiologists who are certified professionals in accordance to Allied Health Professions Act 2016; engaged in an autonomous practice to promote healthy hearing, communication competency, and quality of life for persons of all ages. Audiologist involved in the provision of prevention, identification, assessment, rehabilitation and research of hearing, peripheral or central auditory function, vestibular, balance, and other related systems.</i>				
TOPIC 17E.1: STANDARD 17E.1.1	ORGANISATION AND MANAGEMENT <i>The Audiology Services shall be organised and administered by qualified Audiologists to provide a high standard of audiological service to patients/clients. The services shall encompass the provision of hearing care requirements of all patients in accordance with accepted standards of practice of the profession. In some instances, these services may be collaborated with external sources as well as other rehabilitative services.</i>				
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17E.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Audiology Services are clearly documented and measurable that indicates safety, quality and patient centred care. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.				
	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.			
		2. Goals and objectives of the Audiology Services in line with the Facility statements are available, endorsed and dated.			
		3. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
17E.1.1.2 CORE	There is an organisation chart which: a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head of Audiology Services, consultants, medical practitioners and staff of Audiology Services; b) is accessible to all staff and clients; c) includes off-site services if applicable; d) is revised when there is a major change in any of the following: i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns.			
	EVIDENCE OF COMPLIANCE			
	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head of Audiology Services, consultants, medical practitioners and staff of Audiology Services.			
	2. Organisation chart of the service is endorsed, dated and accessible.			
	3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).			
	Facility Comments:			
17E.1.1.3	The Governing Body shall ensure that Audiology Services are organised in such a way as to: a) facilitate the provision of audiology services to patients in the Facility in a safe, efficient, effective, and caring manner and with due regard for the needs, dignity and privacy of patients and confidentiality of their personal information; b) assure the continuity of care; c) address the professional needs of audiology staff; d) ensure that the relevant staff are involved in the formulation of policies and procedures concerning patient hearing care appropriate to the scope of services of the Facility.			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. The Audiology Services is organised to cover activities but not limited to items (a) to (d) through: a) work assignment schedule to ensure service provision; b) competent staffing level to provide the necessary c) record on continuity of care in patient's medical treatment record; d) Professional Development Plan.			
	Facility Comments:				
17E.1.1.4		Regular staff meetings are held between the Head of audiology Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Audiology Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.			
	EVIDENCE OF COMPLIANCE	1. Minutes are accessible, disseminated and acknowledged by the staff. 2. Attendance list of members with adequate representatives of the service. 3. Frequency of meetings as scheduled. 4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).			
	Facility Comments:				
17E.1.1.5		The Head of Audiology Services is involved in the planning, justification and management of the budget and resource utilisation of the services.			
	EVIDENCE OF COMPLIANCE	1. Minutes of Facility-wide management meeting 2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service. 3. Approved budget and resources.			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17E.1.1.6	The Head of Audiology Services is involved in the appointment and/OR assignment of the staff.					
		1. Appointment/assignment letter of Head of audiology				
		2. Job description of Head of audiology				
		3. Records of staff deployment				
	Facility Comments:					
17E.1.1.7	Appropriate statistics and records shall be maintained in relation to the provision of Audiology Services and used for managing the services and patient care purposes.					
	EVIDENCE OF COMPLIANCE	1. Records are available but not limited to the following:				
		a) workload/census;				
		b) annual report;				
		c) accident/incident reports;				
		d) staffing number and staff profile;				
		e) staff training records;				
		f) data on performance improvement activities, including performance indicators.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
<u>TOPIC 17E.2:</u>	<u>HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT</u>					
<u>STANDARD 17E.2.1</u>	<i>The Audiology Services shall be directed and adequately staffed by qualified and experienced staff to achieve the goals and objectives of the Audiology Services and ensure continuing education and professional development.</i>					
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
17E.2.1.1 CORE	The Head of Audiology and staff of the Audiology Services shall be individuals qualified by education, training, experience and certification to commensurate with the requirements of the various positions. All audiologist shall be registered following the requirements of the Allied Health Professions Act.					
	EVIDENCE OF COMPLIANCE	1. Records on credentials of Head of Service and staff required to fill up the posts within the service (to match the complexity of the Facility and services) and registration (valid Annual Practising Certificate).				
		2. Appointment/assignment letters				
		3. Certification / current practicing certificate				
		4. Training and competency records including privileging				
	Facility Comments:					
17E.2.1.2	The authority, responsibilities and accountabilities of the Head of Audiology Services are clearly delineated and documented.					
	EVIDENCE OF COMPLIANCE	1. Appointment letter for Head of audiology services,				
		2. Description of duties and responsibilities.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17E.2.1.3 CORE	Sufficient number of audiologists and support staff with appropriate qualifications shall be employed to enable the services to meet the documented purposes. Relevant support staff shall work only under supervision of a qualified audiologist.					
	EVIDENCE OF COMPLIANCE	1. Number of staff and qualification should commensurate with workload and regulatory requirements.				
		2. Audiologist and support staff with appropriate qualifications, training and experience are available.				
		3. Staffing pattern				
		4. Duty roster				
		5. Census and statistics				
	Facility Comments:					
17E.2.1.4	There are written and dated specific job descriptions for all categories of staff that include: a) qualifications, training, experience and certification required for the position; b) lines of authority; c) accountability, functions and responsibilities, d) reviewed when required and when there is a major change in any of the following: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations. e) administrative and clinical functions.					
	EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e).				
		2. Job description/ my portfolio includes specialisation skills				
		3. Relevant privileges granted where applicable				
		4. The job description is acknowledged by the staff and signed by the Head of Service and dated.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
17E.2.1.5	Personnel records on training, staff development, leave and others are maintained for every staff. Note: Staff personal record may be kept in Human Resource Department as per Facility policy.			
	EVIDENCE OF COMPLIANCE			
	1. Staff personal records include:			
	a) staff biodata;			
	b) qualification and experience;			
	c) training record;			
	d) competency record and privileging;			
	e) leave record;			
	f) confidentiality agreement.			
	Facility Comments:			
17E.2.1.6	There is a structured orientation programme where new staff are briefed on their services, operational policies and relevant aspects of the Facility to prepare them for their roles and responsibilities.			
	EVIDENCE OF COMPLIANCE			
	1. Policy requiring all new staff to attend a structured orientation programme.			
	2. Records on structured orientation programme			
	3. Orientation Brief			
	4. List of attendance			
	Facility Comments:			
17E.2.1.7	There is evidence of training needs assessment and staff development plan which provides the knowledge and skills required for staff to maintain competency in their current positions and future advancement.			
	EVIDENCE OF COMPLIANCE			
	1. Training needs assessment is carried out and gaps identified.			
	2. A staff development plan based on training needs assessment is available.			
	3. Training schedule/calendar is in place.			
	4. Training module			
	Facility Comments:			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17E.2.1.8	There are continuing education activities for staff to pursue professional interests and to prepare for current and future changes in practice.					
	EVIDENCE OF COMPLIANCE	1. Continuing education activities and schedule				
		2. Contents of training programme				
		3. Training records on continuing education activities are kept and maintained for each staff.				
		4. Certificate of attendance/degree/post grad training				
	Facility Comments:					
17E.2.1.9	Staff receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.					
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff is completed upon probationary period and as an annual exercise.				
	Facility Comments:					
17E.2.1.10	In a Facility where education programme are conducted, the Facility shall ensure that there are sufficient skilled trained staff to provide clinical supervision of students.					
	EVIDENCE OF COMPLIANCE	1. Letter of appointment – Local Preceptor/ Clinical Instructor.				
		2. Memorandum of Understanding with training institution				
		3. Adequate number of clinical instructor to students				
		4. Qualification and training records of local preceptor				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 17E.3: <u>POLICIES AND PROCEDURES</u>						
STANDARD <u>17E.3.1</u>						
<i>There are written and dated policies and procedures for all activities of the Audiology Services. These policies and procedures reflect current standards of audiology services and practice, relevant regulations, statutory requirements, and goals and objectives of the Audiology Services.</i>						
CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17E.3.1.1 CORE	There are written policies and procedures for the Audiology Services which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated. There is a mechanism for and evidence of a periodic review at least once in every three years.					
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for the service. This shall include but not limited to:				
		a) source of referral				
		b) clinical management guidelines				
		c) discharge care plan				
		d) prevention and control of infection				
		e) referral guidelines				
		2. Policies and procedures are consistent with regulatory requirements and current standard practices.				
		3. Evidence of periodic review of policies and procedures.				
	4. The policies and procedures are endorsed and dated.					
Facility Comments:						

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17E.3.1.2 CORE	Policies and procedures are developed by a committee in collaboration with staff, and where appropriate with other external service which include: a) care plan for each patient to achieve appropriate outcome; b) monitoring of the patient to assess the outcome of the care c) modifying the care plan when necessary; d) completing the care plan; e) discharge care plan and follow up; f) prevention and control of infection; g) referral guidelines; h) communication – within and outside the Audiology Services. Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.				
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.			
		2. Minutes of meeting with evidence of cross reference with other departments			
		3. Documented cross departmental policies			
		4. Policies, Procedures, Protocols, Manuals and Guidelines are customised to meet the relevant needs and level of services.			
		5. Clinical documentation cover the following:			
		a) assessment leading to problem list and appropriate clinically reasoned ?? plan of treatment;			
		b) evidence of reviewing outcomes of intervention;			
		c) evidence of modification of treatment plan (as			
		d) evidence of discharge/transfer plan;			
		e) documentation of transfer of care;			
		f) original referral forms.			
		6. Care plan and discharge plan			
	Facility Comments:				
17E.3.1.3	There shall be a policy to address emergency resuscitation in the event of any life threatening situations and the Emergency Resuscitation Team can be alerted immediately, e.g. Code Blue.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	EVIDENCE OF COMPLIANCE	1. Policy for Code Blue within the service area					
		2. Flow chart and contact number of Code Blue made available and accessible.					
	Facility Comments:						
17E.3.1.4	Current policies and procedures are communicated to all staff.						
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings					
		2. Circulation list and acknowledgement					
	Facility Comments:						
17E.3.1.5 CORE	There is evidence of compliance with relevant policies and procedures and standards of practice.						
	EVIDENCE OF COMPLIANCE	1. Compliance with policies and procedures through:					
		a) interview of staff on practices;					
		b) verify with observation on practices;					
		c) Record of care in patient's medical treatment record					
		d) practices in line with established policies and procedures.					
	Facility Comments:						
17E.3.1.6	All outpatients seeking consultation/treatment to the Audiology Services shall be referred by a medical practitioner.						

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Facility policy on referral to allied health services by medical practitioner				
		2. Referral letter/referral form written by medical practitioner				
		3. All patients/clients are registered in the manual register book or electronic system				
		4. Patient's medical record				
	Facility Comments:					
17E.3.1.7	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.					
	EVIDENCE OF COMPLIANCE	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements ie: AHP act 774, Audiology Standard operating procedures(SOP) are accessible on site for staff reference.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT							
TOPIC 17E.4:		<u>FACILITIES AND EQUIPMENT</u>					
<u>STANDARD</u> <u>17E.4.1</u>		<i>Safe and adequate facilities and equipment are available for the delivery of effective audiology services and ensuring patient safety.</i>					
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17E.4.1.1	There is appropriate access to the facility, adequate facilities and equipment with proper utilisation of space to enable staff to carry out their professional, teaching and administrative functions.						
	EVIDENCE OF COMPLIANCE	1. Adequate and proper utilisation of space.					
		2. Appropriate type of equipment to match the complexity of services.					
		3. Adequate facilities and equipment at patient care area for safe care (e.g. access to emergency cart, hand washing facilities, etc).					
		4. Easy access and clear exit routes					
		5. Absence of overcrowding					
	Facility Comments:						
17E.4.1.2	All audiometric booth and audiometers are to be certified by relevant companies registered under Department of Occupational Safety and Health (DOSH)						
	EVIDENCE OF COMPLIANCE	1. Equipment are placed in a planned and systematic manner as evidenced on site.					
		2. Certificate of room calibration by relevant company registered under Department of Occupational Safety and Health (DOSH)					
	Facility Comments:						

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17E.4.1.3	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.				
		1. Testing, commissioning and calibration records (certificates or stickers)			
		2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as EVIDENCE OF COMPLIANCE to the relevant			
	Facility Comments:				
17E.4.1.4 CORE	There is evidence that the facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.				
	EVIDENCE OF COMPLIANCE	1. Planned Preventive Maintenance records such as schedule, stickers, etc.			
		2. Planned Replacement Programme where applicable			
		3. Complaint records			
		4. Asset inventory			
	Facility Comments:				
17E.4.1.5	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.				
	EVIDENCE OF COMPLIANCE	1. User training records			
		2. Competency assessment record			
		3. Letter of authorisation			
		4. List of staff trained and competent to operate specialised equipment			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
17E.4.1.6	Alarm system for emergencies appropriate to client needs shall be made available.					
	EVIDENCE OF COMPLIANCE	1. Emergency alert alarm system, i.e. mechanical and Code Blue is in place.	☐			
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT																
TOPIC 17E.5: SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES																
STANDARD 17E.5.1 <i>The Head of Audiology Services shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Audiology Services.</i>																
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS												
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING											
17E.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Audiology Services. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated. <table border="1"> <tr> <td rowspan="5">EVIDENCE OF COMPLIANCE</td> <td>1. Planned performance improvement activities include (a) to</td> <td></td> </tr> <tr> <td>2. Records on performance improvement activities</td> <td></td> </tr> <tr> <td>3. Minutes of performance improvement meetings</td> <td></td> </tr> <tr> <td>4. Performance improvement studies. If available</td> <td></td> </tr> <tr> <td>5. Records on innovation if available</td> <td></td> </tr> </table> Facility Comments:		EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to		2. Records on performance improvement activities		3. Minutes of performance improvement meetings		4. Performance improvement studies. If available		5. Records on innovation if available				
EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to															
	2. Records on performance improvement activities															
	3. Minutes of performance improvement meetings															
	4. Performance improvement studies. If available															
	5. Records on innovation if available															
17E.5.1.2	The Head of Audiology Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement to appropriate individual/personnel within the respective services. <table border="1"> <tr> <td rowspan="3">EVIDENCE OF COMPLIANCE</td> <td>1. Minutes of meetings</td> <td></td> </tr> <tr> <td>2. Letter of assignment of responsibilities</td> <td></td> </tr> <tr> <td>3. Job description</td> <td></td> </tr> </table> Facility Comments:		EVIDENCE OF COMPLIANCE	1. Minutes of meetings		2. Letter of assignment of responsibilities		3. Job description								
EVIDENCE OF COMPLIANCE	1. Minutes of meetings															
	2. Letter of assignment of responsibilities															
	3. Job description															

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17E.5.1.3	The Head of the Audiology Services shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility.				
	Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.				
	EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:			
		a) Training of staff			
		b) Policy on incident reporting			
		c) Methodology of incident reporting			
		d) Register/records of incidents			
		2. Completed incident reports			
		3. Root Cause Analysis			
		4. Corrective and preventive action plans			
		5. Remedial measure			
	6. Minutes of meetings				
	7. Acknowledgment by Head of Service and PIC/Hospital Director				
	8. Feedback given to staff regarding incident reporting.				
Facility Comments:					
17E.5.1.4 CORE	There is tracking and trending of specific performance indicators not limited to but at least two (2) of the following:				
	A. percentage of new cases given appointment in audiology clinic following a referral within 45 days. (Target: ≥ 85%)				
	B. Percentage of patients received hearing aid provision following the diagnosis of hearing loss within 8 weeks. (Target: ≥ 90%)				
	C. Percentage of patients showing improved hearing ability within 3 months after hearing aid fitting. (Target ≥ 85%)				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored.				
		2. Records on tracking and trending analysis.				
		3. Remedial measures taken where appropriate.				
	Facility Comments:					
17E.5.1.5	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.					
	EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff.				
		2. Evidence of feedback via communication on results of performance improvement activities through continuing education activities/meetings.				
		3. Minutes of service/unit meetings				
	Facility Comments:					
17E.5.1.6	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.					
	EVIDENCE OF COMPLIANCE	1. Documentation on performance improvement activities and performance indicators.				
		2. Policy statement on anonymity on patients and providers involved in performance improvement activities.				
	Facility Comments:					

SERVICE SUMMARY	
SURVEYOR SUMMARY:	
OVERALL RATING:	
OVERALL RISK:	

SURVEY ITEM & SELF-ASSESSMENT						
SERVICE STANDARD 17F : ALLIED HEALTH PROFESSIONAL SERVICES - OPTOMETRY SERVICES						
	<u>PREAMBLE</u> <i>Optometry Services involve the employment of methods for the measurement of the powers of vision, or the adaptation of ophthalmic lenses or prisms for the aid of the powers of vision, or both (Optical Act 1991).</i>					
<u>TOPIC 17F.1:</u> <u>STANDARD 17F.1.1</u>	<u>ORGANISATION AND MANAGEMENT</u> <i>The Optometry Services shall be organised and administered to provide services to patients requiring eye healthcare and other related services in accordance with accepted standards of practice of the profession. The services shall also promote wellness and increase awareness of eye healthcare. In some instances, these services may be provided from sources external to the Facility, organisation or institute.</i>					
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
17F.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Optometry Services are clearly documented and measurable that indicates safety, quality and patient centred care. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.				
		2. Goals and objectives of the Optometry Services in line with the Facility statements are available, endorsed and dated.				
		3. Evidence of planned reviews of the above statements.				
		4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)				
		5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
17F.1.1.2 CORE	There is an organisation chart which: a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head of Optometry Services, consultants, medical practitioners and staff of Optometry Services; b) is accessible to all staff and clients; c) includes off-site services if applicable; d) is revised when there is a major change in any of the following: i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns.			
	EVIDENCE OF COMPLIANCE			
	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head of Optometry Services, consultants, medical practitioners and staff of Optometry Services.			
	2. Organisation chart of the service is endorsed, dated and accessible.			
	3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).			
	Facility Comments:			
17F.1.1.3	The Governing Body shall ensure that Optometry Services are organised in such a way as to : a) facilitate the provision of optometry services to patient in the Facility in a safe, efficient, effective and caring manner and with due regard for the needs, dignity and privacy of patients and confidentiality of their personal information; b) assure the continuity of care; c) address the professional needs of optometry staff; d) ensure that relevant staff are involved in the formulation of policies and procedures concerning eye healthcare appropriate to the scope of services of the Facility.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. The optometry services is organised to cover activities but not limited to items (a) to (d) through:				
		a) work assignment schedule to ensure service provision;				
		b) competent staffing level to provide the necessary				
		c) record on continuity of care in patient's medical treatment record;				
		d) Professional Development Plan.				
	Facility Comments:					
17F.1.1.4	EVIDENCE OF COMPLIANCE	Regular staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Optometry Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.				
		1. Minutes are accessible, disseminated and acknowledged by the staff.				
		2. Attendance list of members with adequate representatives of the service.				
		3. Frequency of meetings as scheduled.				
		4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).				
	Facility Comments:					
17F.1.1.5	EVIDENCE OF COMPLIANCE	The Head of Optometry Services is involved in the planning, justification and management of the budget and resource utilisation of the services.				
		1. Minutes of Facility-wide Management/ Optometry Unit and/OR Ophthalmology Department meeting.				
		2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc)				
		3. Approved budget and resources.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
17F.1.1.6	The Head of Optometry Services is involved in the appointment and/OR assignment of the staff.					
	EVIDENCE OF COMPLIANCE	1. Records on staff interview (if applicable)				
		2. Appointment/assignment letter of Head of Service				
		3. Job description of Head of Service				
		4. Records on staff deployment				
		5. Duty Roster				
	Facility Comments:					
17F.1.1.7	Appropriate statistics and records shall be maintained in relation to the provision of Optometry Services and used for managing the services and patient care purposes.					
	EVIDENCE OF COMPLIANCE	1. Records are available but not limited to the following:				
		a) workload/census;				
		b) annual optometry report;				
		c) accident/incident reports;				
		d) staffing number and staff profile;				
		e) staff training records;				
f) data on performance improvement activities, including performance indicators.						
Facility Comments:						

SURVEY ITEM & SELF-ASSESSMENT								
TOPIC 17F.2:		<u>HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT</u>						
STANDARD <u>17F.2.1</u>		<i>The Optometry Services shall be directed and adequately staffed by qualified and experienced staff to achieve the goals and objectives of the Optometry Services and ensure continuing education and professional development.</i>						
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS				
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING			
17F.2.1.1 CORE	The Head and staff of the Optometry Services shall be individuals qualified by education, training, experience and certification to commensurate with the requirements of the various positions.							
	EVIDENCE OF COMPLIANCE	1. Records on credentials of Head of Service and staff required to fill up the posts within the service (to match the complexity of the Facility and services) and registration.						
		2. All optometrists shall have valid Annual Practising Certificate endorsed by Malaysian Optical Council.						
		3. Appointment/assignment letters						
		4. Certification						
		5. Training and competency records						
	Facility Comments:							
17F.2.1.2	The authority, responsibilities and accountabilities of the Head of Optometry Services are clearly delineated and documented.							
	EVIDENCE OF COMPLIANCE	1. Appointment/assignment letter for Head of Service.						
		2. Description of duties and responsibilities						
	Facility Comments:							

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17F.2.1.3 CORE	Sufficient numbers of optometrists with appropriate qualifications are employed to meet the need of the services.				
	EVIDENCE OF COMPLIANCE	1. Number of staff and qualification should commensurate with workload.			
		2. Staffing pattern			
		3. Duty roster			
		4. Census and statistics			
	Facility Comments:				
17F.2.1.4	There are written and dated specific job descriptions for all categories of staff that include:				
	a) qualifications, training, experience and certification required for the position;				
	b) lines of authority;				
	c) accountability, functions and responsibilities;				
	d) reviewed when required and when there is a major change in any of the following:				
	i) nature and scope of work;				
	ii) duties and responsibilities;				
	iii) general and specific accountabilities;				
	iv) qualifications required;				
	v) staffing patterns;				
vi) Statutory Regulations.					
e) administrative and clinical functions.					
EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e).				
	2. Job description includes specialisation skills				
	3. Relevant privileges granted				
	4. The job description is acknowledged by the staff and signed by the Head of Service and dated.				
Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS					
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING				
17F.2.1.5	Personnel records on training, staff development, leave and others are maintained for every staff.							
	Note: Staff personal record may be kept in Human Resource Department as per Facility policy.							
	EVIDENCE OF COMPLIANCE				1. Staff personal records include:			
					a) staff biodata;			
					b) qualification and experience;			
					c) evidence of current registration;			
					d) training record;			
					e) competency record and privileging;			
					f) leave record;			
	g) confidentiality agreement.							
Facility Comments:								
17F.2.1.6	There is a structured orientation programme where new staff are briefed on their services, operational policies and relevant aspects of the Facility to prepare them for their roles and responsibilities.							
	EVIDENCE OF COMPLIANCE				1. Policy requiring all new staff to attend a structured orientation programme.			
					2. Records on structured orientation programme			
					3. Orientation Brief			
					4. List of attendance			
	Facility Comments:							
	17F.2.1.7				There is evidence of training needs assessment and staff development plan which provides the knowledge and skills required for staff to maintain competency in their current positions and future advancement.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and gaps identified.				
		2. A staff development plan based on training needs assessment is available.				
		3. Training schedule/calendar is in place.				
		4. Training module (if applicable)				
	Facility Comments:					
17F.2.1.8	There are continuing education activities for staff to pursue professional interests and to prepare for current and future changes in practice.					
	EVIDENCE OF COMPLIANCE	1. Continuing education activities and schedule				
		2. Contents of training programme				
		3. Training records on continuing education activities are kept and maintained for each staff.				
		4. Certificate of attendance/degree/post basic training.				
	Facility Comments:					
17F.2.1.9	Staff receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.					
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff is completed upon probationary period and as an annual exercise.				
	Facility Comments:					
17F.2.1.10	In a Facility where education program are conducted, the Facility shall ensure that there are sufficient skilled trained staff to provide clinical supervision of students.					
	EVIDENCE OF COMPLIANCE	1. Letter of appointment – Local Preceptor/Clinical Instructor.				
		2. Memorandum of Understanding with training institution				
		3. Adequate number of Local Preceptor/Clinical Instructor to students				
		4. Qualification and training records of local preceptor (if applicable)				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING

SURVEY ITEM & SELF-ASSESSMENT					
<u>TOPIC 17F.3:</u>	<u>POLICIES AND PROCEDURES</u>				
<u>STANDARD</u> <u>17F.3.1</u>	<i>There are written and dated policies and procedures for all activities of the Optometry Services. These policies and procedures reflect current standards of optometry services and practice, relevant regulations, statutory requirements, and goals and objectives of the services.</i>				
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17F.3.1.1 CORE	There are written policies and procedures for the Optometry Services which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated.				
	There is a mechanism for and evidence of a periodic review at least once in every three years.				
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for the service.			
		2. Policies and procedures are consistent with regulatory requirements and current standard practices.			
		3. Evidence of periodic review of policies and procedures.			
		4. The policies and procedures are endorsed and dated.			
	Facility Comments:				
17F.3.1.2	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved.				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS			
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.						
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.					
		2. Minutes of meeting with evidence of cross reference with other departments (if applicable)					
		3. Documented cross departmental policies (if applicable)					
	Facility Comments:						
17F.3.1.3	There shall be a policy to address emergency resuscitation in the event of any life threatening situations and the Emergency Resuscitation Team can be alerted immediately, e.g. Code Blue.						
	EVIDENCE OF COMPLIANCE	1. Policy for Code Blue within the service area					
		2. Flow chart and contact number of Code Blue made available and accessible.					
	Facility Comments:						
17F.3.1.4	Current policies and procedures are communicated to all staff.						
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings					
		2. Circulation list and acknowledgement					
	Facility Comments:						

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17F.3.1.5 CORE	There is evidence of compliance with policies and procedures and standard of practice which include but not limited to the following: a) usage, dosage and storage of pharmaceuticals and contact lens solutions are in keeping with the recommendation of the manufacturer; b) appropriate practice of hygiene and infection control; c) provide appropriate instruction to patients on the prescription for spectacles, prism, contact lenses, low vision devices and visual therapy.				
	EVIDENCE OF COMPLIANCE	1. Standard Operating Procedures (SOP) shall cover items (a) to (c).			
		2. Compliance with policies and procedures through:			
		a) interview of staff on practices;			
		b) verify with observation on practices;			
		c) results of audit on practices;			
		d) practices in line with established policies and			
	Facility Comments:				
17F.3.1.6	All outpatients seeking consultation/treatment to the Optometry Services shall be referred by a medical practitioner / certified optometrist / teachers from school health team screening / AVIS program				
	EVIDENCE OF COMPLIANCE	1. Documented facility policy on referral to allied health services			
		2. Referral letter/referral form written by medical practitioner / certified optometrist / teachers from school health screening / AVIS program			
		3. All patients/clients are registered in the manual register book or electronic system			
		4. Patient's medical record			
	Facility Comments:				
17F.3.1.7	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements i.e. Optical Act 1991, Optometry Standard Operating Procedures (SOP) are accessible on-site for staff reference.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT							
TOPIC 17F.4:		<u>FACILITIES AND EQUIPMENT</u>					
<u>STANDARD</u> <u>17F.4.1</u>		<i>Safe and adequate facilities and equipment are available for the delivery of effective optometry services and ensuring patient safety.</i>					
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17F.4.1.1	There is appropriate access to the facility, adequate facilities and equipment with proper utilisation of space to enable staff to carry out their professional, teaching and administrative functions.						
	EVIDENCE OF COMPLIANCE	1. Adequate and proper utilisation of space.					
		2. Appropriate type of equipment to match the complexity of services.					
		3. Adequate facilities and equipment at patient care area for safe care (e.g. access to emergency cart, hand washing facilities, etc).					
		4. Easy access and clear exit routes					
		5. Absence of overcrowding					
	Facility Comments:						
17F.4.1.2	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.						
	EVIDENCE OF COMPLIANCE	1. Adequate equipment and supplies for optometry services.					
		2. Testing, commissioning and calibration records (certificates or stickers)					
		3. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as EVIDENCE OF COMPLIANCE to the relevant					
	Facility Comments:						

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17F.4.1.3 CORE	There is evidence that the facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.				
	EVIDENCE OF COMPLIANCE	1. Planned Preventive Maintenance records such as schedule, stickers, etc.			
		2. Planned Replacement Programme where applicable			
		3. Complaint records			
		4. Asset inventory			
	Facility Comments:				
17F.4.1.4	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.				
	EVIDENCE OF COMPLIANCE	1. User training records			
		2. Competency assessment record			
		3. List of staff trained and competent to operate specialised equipment			
	Facility Comments:				
17F.4.1.5	Examination room shall be set up according to standards to enable precise measurement.				
	EVIDENCE OF COMPLIANCE	1. List of Standard and Alternative Facilities in the Optometry Standard Operating Procedures is to be used as reference in setting up of Optometry examination room.			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
17F.4.1.6	Alarm system for emergencies appropriate to client needs shall be made available.				
	EVIDENCE OF COMPLIANCE	1. Emergency alert alarm system i.e. mechanical and Code Blue is in place			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 17F.5:		SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES				
STANDARD 17F.5.1		The Head of Optometry Services shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Optometry Services.				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17F.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Optometry Services. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.					
	EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to (f).				
		2. Records on performance improvement activities.				
		3. Minutes of performance improvement meetings.				
		4. Performance improvement studies.				
		5. Records on innovation if available.				
	Facility Comments:					
17F.5.1.2	The Head of Optometry Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement to appropriate individual/personnel within the respective services.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes of meetings				
		2. Letter of assignment of responsibilities				
		3. Job description				
	Facility Comments:					
17F.5.1.3	The Head of the Optometry Services shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility. Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.					
	EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:				
		a) Training of staff				
		b) Policy on incident reporting				
		c) Methodology of incident reporting				
		d) Register/records of incidents				
		2. Completed incident reports				
		3. Root Cause Analysis				
		4. Corrective and preventive action plans				
		5. Remedial measure				
		6. Minutes of meetings				
		7. Acknowledgment by Head of Service and PIC/Hospital Director				
		8. Feedback given to staff regarding incident reporting.				
	Facility Comments:					
17F.5.1.4 CORE	There is tracking and trending of specific performance indicators not limited to but at least two (2) of the following: a) Percentage of keratoconus case have complications after RGP contact lens					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS				
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING			
	delivery (Target: ≤ 20%) b) Optometrist outreach (Target: twice a year achieved 100%) c) New cases achieving best corrected visual acuity 6/6 after refraction. (Target: ≥ 85%) d) Percentage new patient that were given appointment for refraction procedure within ≤ 6 weeks in Optometry Clinic without Ophthalmologist (Target: ≥ 80%) e) Percentage new patient that were given appointment for diabetic retinopathy screening within ≤ 6 weeks in optometry Clinic at Klinik Kesihatan (Target: ≥ 80%) f) Waiting time to see optometrist after registration (Target: 80% within 60 minutes)							
	EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored.						
		2. Records on tracking and trending analysis.						
		3. Remedial measures taken where appropriate.						
	Facility Comments:							
17F.5.1.5	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.							
	EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff.						
		2. Evidence of feedback via communication on results of performance improvement activities through continuing education activities/meetings.						
		3. Minutes of service/unit meetings						
	Facility Comments:							

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17F.5.1.6	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.					
	EVIDENCE OF COMPLIANCE	1. Documentation on performance improvement activities and performance indicators.				
		2. Policy statement on anonymity on patients and providers involved in performance improvement activities.				
	Facility Comments:					

SERVICE SUMMARY**SURVEYOR SUMMARY:****OVERALL RATING:****OVERALL RISK:**

SURVEY ITEM & SELF-ASSESSMENT				
SERVICE STANDARD 17G : ALLIED HEALTH PROFESSIONAL SERVICES – HEALTH EDUCATION SERVICES				
	<u>PREAMBLE</u> <i>The Health Education Services shall offer health education, wellness promotion and prevention to inpatients, outpatients and staffs and the community (including exhibition, talks etc outside hospital) in an efficient and effective manner and shall be organised, directed, integrated and coordinated with other services in the Facility/community. The scopes of Health Education Services shall be provided by appropriately trained health personnel and shall include production of health education materials, health promotion and intervention programmes/activities. Intervention programmes include behavioural needs assessment, behavioural modification and evaluation (cognitive, affective and psychomotor) to educate and encourage patients and community to comply with the treatment regime offered in controlling their diseases and maintaining wellbeing.</i>			
<u>TOPIC 17G.1:</u> <u>STANDARD 17G.1.1</u>	<u>ORGANISATION AND MANAGEMENT</u> <i>The Health Education Services shall be organised and administered to provide services to outpatients, inpatients and staffs and the community (including exhibition, talks etc outside hospital) in efficient and effective manner and shall be integrated and coordinated with all clinical services in accordance with accepted standards of practice.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
17G.1.1.1	Vision, Mission and values statements of the Facility are accessible (if only you are provided with your own Unit or working station and not sharing with other Services). Goals and objectives that suit the scope of the Health Education Services are clearly documented and measurable that indicates safety, quality and patient centred care. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body					
		2. Goals and objectives of the Health Education Services in line with the Facility statements are available, endorsed and dated					
		3. Evidence of planned reviews of the above statements.					
		4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)					
		5. Achievement of goals and objectives are monitored, reviewed and revised accordingly					
	Facility Comments:						
17G.1.1.2 CORE	There is an organisation chart which: a) provides a clear representation of the structure, function and reporting relationships between the Head and staff of Health Education Services; b) is accessible to all staff and clients; c) is revised when there is a major change in any of the following: i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns.						
	EVIDENCE OF COMPLIANCE	1. Clearly delineated current organisation chart with line of functions and reporting relationships.					
		2. Organisation chart of the service is endorsed, dated and accessible.					
		3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).					
	Facility Comments:						

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
17G.1.1.3 CORE	The Governing Body shall ensure that Health Education Services are organised in such a way as to:			
	a) facilitate the provision of health education services to patients in the Facility in a safe, efficient, effective and caring manner and with due regards for the needs, dignity and privacy of patients and confidentiality of their personal information; if you are provided with i. locked tier-cabinet/drawer for patient files ii. consultation room *(if none must show evidence e.g. asset application form or relevant documents)			
	b) address the professional needs of health education staff; (by an authorized direct Officer e.g. Medical Assistant Director)			
	c) ensure the relevant staff are involved in the formulation of policies and procedure concerning patient care appropriate to the scope of services of the Facility;			
	d) be the focal point in activities which include health personnel, production of health education material, health promotion and intervention programmes;			
	e) favourably change cognitive, affective and psychomotor behavior of the patients in maintaining their health and wellbeing.			
EVIDENCE OF COMPLIANCE	1. Annual health education action plan which includes planned programmes and activities of the year involving patients (such as list of specific patient education face-to-face interventions or online – new norms) or community or staff (e.g. annual special health day celebration including World Diabetes Day, Tobacco Free Weeks and World AIDS Day)			
	2. Documents or records on the patients who received behavioural need assessment and evaluation using any related tools and instruments to substantially measure and evaluate the cognitive, affective and psychomotor behaviour (be it in combination or otherwise) of patients in need of health education intervention.			
	3. Records on health education material productions (printed or electronic); in-house or otherwise; either being requested by any parties or based on internal needs of the facility's health education programmes and activities (such as records book/request form/emails/google form)			
Facility Comments:				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS				
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING			
17G.1.1.4	Regular staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Health Education Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.								
	EVIDENCE OF COMPLIANCE	1. Minutes are accessible, disseminated and acknowledged by the staff.							
		2. Attendance list of members with adequate representatives of the service.							
		3. Frequency of meetings as scheduled.							
		4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).							
	Facility Comments:								
17G.1.1.5	The Head of Health Education Services is involved in the planning, justification and management of the budget and resource utilisation of the services.								
	EVIDENCE OF COMPLIANCE	1. Minutes of Facility-wide management meeting							
		2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc)							
		3. Approved budget and resources.							
	Facility Comments:								
17G.1.1.6	The Head of Health Education Services is involved in the appointment and/OR assignment of staff.								
		1. Appointment /assignment letter of Head of Service							
		2. Job description of Head of Service							
		3. Records on staff deployment							
		4. Duty roster							
	Facility Comments:								

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
17G.1.1.7	Appropriate statistics and records shall be maintained in relation to the provision of Health Education Services and used for managing the services and patient care purposes.				
	EVIDENCE OF COMPLIANCE	1. Records are available but not limited to the following:			
		a) workload/census - Number of health education activities/programmes;			
		b) annual report;			
		c) accident/incident reports;			
		d) staffing number and staff profile;			
		e) staff training records; (attach course evaluation and effectiveness questionnaire)			
		f) tracking and trending data on performance improvement activities, including performance indicators. *data should be presented to be seen such as bar charts/pie charts, etc			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT								
<u>TOPIC 17G.2</u>	<u>HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT</u>							
<u>STANDARD 17G.2.1</u>	<i>The Health Education Services shall be directed and adequately staffed by qualified and experienced staff to achieve the goals and objectives of the Health Education Services and ensure continuing education and professional development.</i>							
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS				
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING			
17G.2.1.1 CORE	The Head and staff of the Health Education Services shall be individuals qualified by education, training, experience and certification to commensurate with the requirements of the various positions.							
	EVIDENCE OF COMPLIANCE	1. Records on credentials of Head of Service and staff required to fill up the posts within the service and registration (Health Education Officer, has a degree or Post Graduate Certificate from Institute for Health Behaviour Research.)						
		2. Appointment/assignment letters						
		3. Certification						
		4. Training and competency records						
	Facility Comments:							
17G.2.1.2	The authority, responsibilities and accountabilities of the Head of Health Education Services are clearly delineated and documented.							
	EVIDENCE OF COMPLIANCE	1. Appointment/assignment letter for Head of Service.						
		2. Description of duties and responsibilities						
	Facility Comments:							
17G.2.1.3 CORE	Sufficient numbers of competent personnel and support staff with appropriate qualifications are employed to enable the services to meet the need of the services.							

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	Relevant support staff shall work only under supervision of a qualified health education officer.					
	EVIDENCE OF COMPLIANCE	1. Number of staff and qualification should commensurate with workload.				
		2. Data from Workload Indicator for Staffing Need (WISN) from the Health Education Division, Ministry of Health Malaysia.				
		3. Staffing pattern				
		4. Duty roster				
		5. Census and statistics				
	Facility Comments:					
17G.2.1.4	There are written and dated specific job descriptions for all categories of staff that include: a) qualifications, training, experience and certification required for the position; b) lines of authority; c) accountability, functions and responsibilities; d) reviewed when required and when there is a major change in any of the following: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations.					
	EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (d).				
		2. Job description				
		3. The job description is acknowledged by the staff and signed by the Head of Service and dated.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
17G.2.1.5	Personnel records on training, staff development, leave and others are maintained for every staff. Note: Staff personal record may be kept in Human Resource Department as per Facility policy.			
	EVIDENCE OF COMPLIANCE			
	1. Staff personal records include:			
	a) staff biodata;			
	b) qualification and experience;			
	c) training record;			
	d) competency record and privileging;			
	e) leave record;			
	f) confidentiality agreement.			
	Facility Comments:			
17G.2.1.6	There is a structured orientation programme where new staff are briefed on their services, operational policies and relevant aspects of the Facility to prepare them for their roles and responsibilities.			
	EVIDENCE OF COMPLIANCE			
	1. Policy requiring all new staff to attend a structured orientation programme.			
	2. Records on structured orientation programme			
	3. Orientation Brief			
	4. List of attendance			
	Facility Comments:			
17G.2.1.7	There is evidence of training needs assessment and staff development plan which provides the knowledge and skills required for staff to maintain competency in their current positions and future advancement.			
	EVIDENCE OF COMPLIANCE			
	1. Training needs assessment is carried out and gaps identified.			
	2. A staff development plan based on training needs assessment is available.			
	3. Training schedule/calendar is in place.			
	4. Training module			
	Facility Comments:			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
17G.2.1.8	There are continuing education activities for staff to pursue professional interests and to prepare for current and future changes in practice.					
	EVIDENCE OF COMPLIANCE	1. Continuing education activities and schedule				
		2. Contents of training programme				
		3. Training records on continuing education activities are kept and maintained for each staff.				
		4. Certificate of attendance/degree/post basic training				
	Facility Comments:					
17G.2.1.9	Staff receive appraisal of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.					
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff is completed upon probationary period and as an annual exercise.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 17G.3:		POLICIES AND PROCEDURES				
STANDARD 17G.3.1		There are written and dated policies and procedures for all activities of the Health Education Services. These policies and procedures reflect current standards of health education services and practice, relevant regulations, statutory requirements, and the goals and objectives of the services.				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17G.3.1.1 CORE	There are written policies and procedures for the Health Education Services which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated.					
	There is a mechanism for and evidence of a periodic review at least once in every three years.					
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for the service.				
		2. Policies and procedures are consistent with regulatory requirements and current standard practices.				
		3. Evidence of periodic review of policies and procedures.				
		4. The policies and procedures are endorsed and dated.				
Facility Comments:						
17G.3.1.2	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved.					
	Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.				
		2. Minutes of meeting with evidence of cross reference with other departments				
		3. Documented cross departmental policies				
	Facility Comments:					
17G.3.1.3	There shall be a policy to address emergency resuscitation in the event of any life threatening situations and the Emergency Resuscitation Team can be alerted immediately, e.g. Code Blue.					
	EVIDENCE OF COMPLIANCE	1. Policy for Code Blue within the service area (staff are aware)				
		2. Flow chart and contact number of Code Blue made available and accessible				
	Facility Comments:					
17G.3.1.4	Current policies and procedures are communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings				
		2. Circulation list and acknowledgement				
	Facility Comments:					
17G.3.1.5 CORE	There is evidence of compliance with policies and procedures and standards of practice.					
	EVIDENCE OF COMPLIANCE	1. Compliance with policies and procedures through:				
		a) interview of staff on practices;				
		b) verify with observation on practices;				
		c) results of audit on practices;				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
		d) practices in line with established policies and procedures.					
		2. No incidents reported on non-compliance to policies and procedures and standard practices					
	Facility Comments:						
17G.3.1.6 CORE	All in-house production of health education materials (printed or electronic) shall be pretested before being produced.						
	EVIDENCE OF COMPLIANCE	1. Records on in-house health education materials to be printed are pre-tested accordingly using standard format or tool.					
		2. Evidence of improvement and amendment made to health education materials based on pre-test evaluation result.					
	Facility Comments:						
17G.3.1.7 CORE	Health education services to patients shall be documented in patient's medical record or any form of health education reporting system which comprises needs assessment, behavior diagnosis, plan for patient education intervention and evaluation.						
	EVIDENCE OF COMPLIANCE	1. Documents or records on the patients who received behavioural needs assessment and evaluation using any related tools and instruments to substantially measure and evaluate the cognitive, affective and psychomotor behaviour (be it in combination or otherwise) of the patients need for health education intervention.					
		Facility Comments:					
17G.3.1.8	All outpatients seeking consultation/information from the Health Education Services shall be referred by a medical practitioner. (if patient walked-in to Outpatient Clinic or walked-in direct to Health Education Unit?)						
	EVIDENCE OF COMPLIANCE	1. Referral letter/referral form written by medical practitioner					
		2. All patients/clients are registered in the manual register book or electronic system.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		3. Patient's medical record				
	Facility Comments:					
17G.3.1.9	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.					
	EVIDENCE OF COMPLIANCE	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT								
TOPIC 17G.4:		<u>FACILITIES AND EQUIPMENT</u>						
<u>STANDARD 17G.4.1</u>		<i>Safe and adequate facilities and equipment are available for the delivery of effective Health Education Services and ensuring patient safety.</i>						
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
17G.4.1.1	There is appropriate access to the facility, adequate facilities and equipment with proper utilisation of space to enable staff to carry out their professional, teaching and administrative functions.							
	EVIDENCE OF COMPLIANCE	1. Adequate and proper utilisation of space.						
		2. Appropriate type of equipment to match the complexity of services.						
		3. Adequate facilities and equipment (e.g., hand washing facilities, etc)						
		4. Easy access and clear exit routes						
		5. Absence of overcrowding						
	Facility Comments:							
17G.4.1.2	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.							
	EVIDENCE OF COMPLIANCE	1. Testing, commissioning and calibration records (certificates or stickers)						
		2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as evidence of compliance to the relevant standards and Acts.						
	Facility Comments:							
17G.4.1.3	There is evidence that the facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.							

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Planned Preventive Maintenance records such as schedule, stickers, etc.				
		2. Planned Replacement Programme where applicable				
		3. Complaint records				
		4. Asset inventory				
	Facility Comments:					
17G.4.1.4	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.					
	EVIDENCE OF COMPLIANCE	1. User training records				
		2. Competency assessment record				
		3. Letter of authorisation				
		4. List of staff trained and competent to operate specialised equipment				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT					
<u>TOPIC 17G.5:</u>		<u>SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES</u>			
<u>STANDARD 17G.5.1</u>		<i>The Head of Health Education Services shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Health Education Services.</i>			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
17G.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Health Education Services. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.				
EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to (f).				
	2. Records on performance improvement activities.				
	3. Minutes of performance improvement meetings.				
	4. Performance improvement studies				
	5. Records on innovation if available				
Facility Comments:					
17G.5.1.2	The Head of Health Education Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement to appropriate individual/personnel within the respective services.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes of meetings				
		2. Letter of assignment of responsibilities				
		3. Job description				
		Facility Comments:				
17G.5.1.3	The Head of the Health Education Services shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility. Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.					
	EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:				
		a) Training of staff				
		b) Policy on incident reporting				
		b) Methodology of incident reporting				
		c) Register/records of incidents				
		2. Completed incident reports				
		3. Root Cause Analysis				
		4. Corrective and preventive action plans				
		5. Remedial measure				
		6. Minutes of meetings				
	7. Acknowledgment by Head of Service and PIC/Hospital Director					
	8. Feedback given to staff regarding incident reporting.					
	Facility Comments:					
17G.5.1.4 CORE	There is tracking and trending of specific performance indicators not limited to but at least two (2) of the following:					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	a) number of patients received behavioral need assessment (cognitive, affective & psychomotor) prior to health education intervention b) Percentage of successful quit smoking after 6 months from setting Quit Date (Target: 35%) c) Percentage of patient referrals seen within two (2) weeks (Target: 80%) d) Percentage of successful clients to reduce bodyweight (weight management program) (Target 10%)					
EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored.					
	2. Records on tracking and trending analysis.					
	3. Remedial measures taken where appropriate					
Facility Comments:						
17G.5.1.5	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.					
EVIDENCE OF COMPLIANCE	1. Results on performance improvement activities are accessible to staff.					
	2. Evidence of feedback via communication on results of performance improvement activities through continuing education activities/meetings.					
	3. Minutes of service/unit meetings					
Facility Comments:						
17G.5.1.6	Appropriate documentation of performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	EVIDENCE OF COMPLIANCE	1. Documentation on performance improvement activities and performance indicators.						
		2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						
	Facility Comments:							

SERVICE SUMMARY	
SURVEYOR SUMMARY:	
OVERALL RATING:	
OVERALL RISK:	

SURVEY ITEM & SELF-ASSESSMENT						
SERVICE STANDARD 17H : ALLIED HEALTH PROFESSIONAL SERVICES – MEDICAL SOCIAL WORK SERVICES						
	<u>PREAMBLE</u> <i>The Medical Social Services is responsible to provide psychosocial assistance to patients and/or family members through biopsychosocial assessment, support therapy and practical assistance interventions focusing on casework, group work and community work. The support therapy interventions involve consultation, emotional support and crisis interventions while practical assistance intervention involve aspects of financial assistance for acute and chronic patients. Institutional placement and tracking down patient's relatives. Medical Social Worker works in collaborative networking with various medical profession disciplines, government and non-government agencies and local community.</i>					
<u>TOPIC 17H.1:</u> <u>STANDARD 17H.1.1</u>	<u>ORGANISATION AND MANAGEMENT</u> <i>The Medical Social Work Services shall be organised and administered to provide services to patients requiring medical social work assistance and other related services in accordance with accepted standards of practices. This includes networking with government and non-governmental organisations in the community.</i>					
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
17H.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Medical Social Services are clearly documented and measurable that indicates safety, quality and patient centred care. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.				
		2. Goals and objectives of the Medical Social Services in line with the Facility statements are available, endorsed and				
		3. Evidence of planned reviews of the above statements.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)				
		5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.				
	Facility Comments:					
17H.1.1.2 CORE	There is an organisation chart which: a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head of Medical Social Work Services, consultants, medical practitioners and staff of Medical Social Work Services; b) is accessible to all staff and clients; c) includes off-site services if applicable; d) is revised when there is a major change in any of the following: i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns.					
	EVIDENCE OF COMPLIANCE	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head of Medical Social Services, consultants, medical practitioners and staff of Medical Social Services.				
		2. Organisation chart of the service is endorsed, dated and accessible.				
		3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).				
	Facility Comments:					
17H.1.1.3 CORE	The Governing Body shall ensure that Medical Social Work Services are organised in such a way as to: a) facilitate the provision of medical social work services to patients in the Facility in a safe, efficient, effective and caring manner and with due regards for the needs, dignity and privacy of patients and confidentiality of their personal					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	information; b) assure continuity of care is assured; c) address the professional needs of medical social work staff; d) ensure the relevant staff are involved in the formulation of policies and procedure concerning patient care appropriate to the scope of services of the Facility.					
	EVIDENCE OF COMPLIANCE				1. The Medical Social Services is organised to cover activities but not limited to items (a) to (d) through:	
					a) work assignment schedule to ensure service provision;	
					b) competent staffing level to provide the necessary	
					c) record on continuity of care in patient's medical treatment record;	
					d) Professional Development Plan.	
					e) Informed Consent Form is provided to protect the privacy and confidentiality of the patient's information	
					2. Consultation rooms are conducive for interview of the patient especially for unmarried mother, child abuse and domestic violence cases etc.	
					3. Transportation for home visit and follow up cases to ensure continuity of care given to patient.	
	4. Participation and involvement in inter and multi-disciplinary review team.					
	Facility Comments:					
17H.1.1.4	Regular staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Medical Social Work Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.					
	EVIDENCE OF COMPLIANCE				1. Minutes are accessible, disseminated and acknowledged by the staff.	
					2. Attendance list of members with adequate representatives of the service.	

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		3. Frequency of meetings as scheduled.				
		4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).				
		Facility Comments:				
17H.1.1.5	Personnel records on training, staff development, leave and others are maintained for every staff. Note: Staff personal record may be kept in Human Resource Department as per Facility policy.					
	EVIDENCE OF COMPLIANCE	1. Staff personal records include:				
		a) staff biodata;				
		b) qualification and experience;				
		c) training record;				
		d) competency record and privileging;				
		e) leave record;				
		f) confidentiality agreement.				
		Facility Comments:				
17H.1.1.6	The Head of Medical Social Work Services is involved in the planning, justification and management of the budget and resource utilisation of the services.					
	EVIDENCE OF COMPLIANCE	1. Minutes of Facility-wide management meeting				
		2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service.				
		3. Approved budget and resources.				
		Facility Comments:				
17H.1.1.7	The Head of Medical Social Work Services is involved in the appointment and/OR assignment of staff.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Records on staff interview (if applicable)				
		2. Appointment/assignment letter of Head of Service				
		3. Job description of Head of Service				
		4. Records on staff deployment				
	Facility Comments:					
17H.1.1.8	Appropriate statistics and records shall be maintained in relation to the provision of Medical Social Work Services and used for managing the services and patient care purposes.					
	EVIDENCE OF COMPLIANCE	1. Records are available but not limited to the following:				
		a) workload/census;				
		b) annual report;				
		c) accident/incident reports;				
		d) staffing number and staff profile;				
		e) staff training records;				
		f) data on performance improvement activities, including performance indicators.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
<u>TOPIC 17H.2</u>		<u>HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT</u>				
<u>STANDARD 17H.2.1</u>		<i>The Medical Social Work Services shall be directed and adequately staffed by qualified and experienced staff to achieve the goals and objectives of the Medical Social Work Services and ensure continuing education and professional development.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17H.2.1.1 CORE	The Head and staff of the Medical Social Work Services shall be individuals qualified by education, training, experience and certification to commensurate with the requirements of the various positions.					
	All Medical Social Worker Officers shall be registered following the requirements of the Allied Health Professions Act.					
	Note Medical Social Work Officer is an individual who is trained and registered as a Medical Social Work Officer to conduct social/behavioral assessment and intervention, manage biopsychosocial problems and provide consultation to individuals, their family members or caregivers. Their minimum academic qualification is Bachelor Degree of Social Science with Honor (Social Work Studies) or equivalent or recognized by MQA.					
	EVIDENCE OF COMPLIANCE	1. Records on credentials of Head of Service and staff required to fill up the posts within the service (to match the complexity of the Facility and services) and registration.				
		2. Appointment/assigning letters				
		3. Certification				
		4. Training and competency records				
Facility Comments:						
17H.2.1.2	The authority, responsibilities and accountabilities of the Head of Medical Social Services are clearly delineated and documented.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Appointment/assignment letter for Head of Service.				
		2. Description of duties and responsibilities.				
	Facility Comments:					
17H.2.1.3 CORE	Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the need of the services.					
	Relevant support staff shall work under the supervision of a qualified medical social work officer.					
	EVIDENCE OF COMPLIANCE	1. Sufficient number of Medical Social Workers Officers and relevant support staff are available depending on types of healthcare facility in the public sector as follows:				
		a) State facility				
		b) Major specialist facility				
		c) Minor Specialist facility				
		d) Non-specialist facility				
		2. Number of staff and qualification commensurate with workload.				
		3. Staffing pattern				
		4. Census and statistics				
	Facility Comments:					
17H.2.1.4	There are written and dated specific job descriptions for all categories of staff that include:					
	a) qualifications, training, experience and certification required for the position;					
	b) lines of authority;					
	c) accountability, functions and responsibilities,					
	d) reviewed when required and when there is a major change in any of the following:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations.			
	EVIDENCE OF COMPLIANCE 1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (d). 2. Job description 3. The job description is acknowledged by the staff and signed by the Head of Service and dated.			
	Facility Comments:			
17H.2.1.5	Personnel records on training, staff development, leave and others are maintained for every staff. Note: Staff personal record may be kept in Human Resource Department as per Facility policy. EVIDENCE OF COMPLIANCE 1. Staff personal records include: a) staff biodata; b) qualification and experience; c) training record; d) competency record and privileging; e) leave record; f) confidentiality agreement. Facility Comments:			
17H.2.1.6	There is a structured orientation programme where new staff are briefed on their services, operational policies and relevant aspects of the Facility to prepare them for their roles and responsibilities.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme.				
		2. Records on structured orientation programme				
		3. Orientation Brief				
		4. List of attendance				
	Facility Comments:					
17H.2.1.7	There is evidence of training needs assessment and staff development plan which provides the knowledge and skills required for staff to maintain competency in their current positions and future advancement.					
	EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and gaps identified.				
		2. A staff development plan based on training needs assessment is available.				
		3. Training schedule/calendar is in place.				
		4. Training module				
	Facility Comments:					
17H.2.1.8	There are continuing education activities for staff to pursue professional interests and to prepare for current and future changes in practice.					
	EVIDENCE OF COMPLIANCE	1. Continuing education activities and schedule				
		2. Contents of training programme				
		3. Training records on continuing education activities are kept and maintained for each staff.				
		4. Certificate of attendance/degree/post graduate training.				
	Facility Comments:					
17H.2.1.9	Staff receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff is completed upon probationary period and as an annual exercise.				
	Facility Comments:					
17H.2.1.10	In a facility where educational programs are conducted, the Facility shall ensure that there are sufficient skilled trained staff to provide clinical supervision of students.					
EVIDENCE OF COMPLIANCE	1. Letter of appointment – Local Preceptor/ Clinical Instructor.					
	2. Memorandum of Understanding with training institution					
	3. Adequate number of clinical instructor to students					
	4. Qualification and training records of local preceptor					
Facility Comments:						

SURVEY ITEM & SELF-ASSESSMENT				
TOPIC 17H.3:		<u>POLICIES AND PROCEDURES</u>		
STANDARD 17H.3.1		<i>There are written and dated policies and procedures for all activities of the Medical Social Work Services. These policies and procedures reflect current standards of medical social work services and practice, relevant regulations, statutory requirements, and the goals and objectives of the Medical Social Work Services.</i>		
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
17H.3.1.1 CORE	There are written policies and procedures for the Medical Social Work Services which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated and reference made to relevant Acts/guidelines pertaining to psychosocial issues as follows: i) Child Act 2001 ii) Domestic Violence Act 1994 iii) Operational Management Plan for Medical Social Work Services (Buku Pelan Pengurusan Operasi Perkhidmatan Kerja Sosial Perubatan) iv) Standard Operational Procedure for Support Therapy Assistance Management (Buku Prosedur Operasi Standard Pengurusan Bantuan Terapi Sokongan) v) Standard Operational Procedure for Practical Assistance Management (Buku Prosedur Operasi Standard Pengurusan Bantuan Praktic) vi) Practical Guidelines for medical social workers in ministry of Health (Buku Garis panduan Laporan Sosio Ekonomi Pegawai Kerja Sosial Perubatan Kementerian Kesihatan Malaysia) vii) Code of Ethics for Medical Social Officer There is a mechanism for and evidence of a periodic review at least once in every three years.			
EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for the Medical Social Work Services.			
	2. Policies and procedures are consistent with regulatory requirements and current standard practices that include issues addressed in (i) to (vii).			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		3. Operational Management Plan for Medical Social Work Services, Standard Operational Procedure for Support Therapy Assistance management and Standard Operational for Practical Assistance Management is Available.				
		4. Evidence of periodic review of policies and procedures.				
		5. The policies and procedures are endorsed and dated.				
	Facility Comments:					
17H.3.1.2 CORE	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved and shall include: a) confidentiality of client information in line with regulatory requirements; b) documentation of biopsychosocial intervention plan; c) assessment; d) diagnosis; e) types of assistance; f) monitoring and evaluation; g) consultation with the medical practitioner; and shall be recorded in the patient's medical record. Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.					
EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures that cover items (a) to (g).					
	2. Minutes of meeting with evidence of cross reference with other departments					
	3. Documented cross departmental policies					
	4. Clinical documentation in patient's medical records include:					
	a) referral form from Medical Officer/Specialist to Medical Social Workers;					
	b) Informed Consent Form for patient					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		c) Biopsychosocial assessment form by Medical Social Work Officer:				
		d) Case note from by Medical Social Work Officer for case chronology				
	Facility Comments:					
17H.3.1.3	There shall be a policy to address emergency resuscitation in the event of any life threatening situations and the Emergency Resuscitation Team can be alerted immediately, e.g. Code Blue.					
	EVIDENCE OF COMPLIANCE	1. Policy for Code Blue within the service area.				
		2. Flow chart and contact number of code blue made available and accessible.				
	Facility Comments:					
17H.3.1.4	Current policies and procedures are communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings				
		2. Circulation list and acknowledgement				
	Facility Comments:					
17H.3.1.5 CORE	There is evidence of compliance with policies and procedures and standards of practice.					
	EVIDENCE OF COMPLIANCE	1. Compliance with policies and procedures through:				
		a) interview of staff on practices;				
		b) verify with observation on practices;				
		c) results of audit on practices;				
		d) practices in line with established policies and				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17H.3.1.6	All outpatients seeking consultation/counseling assistance from the Medical Social Work Services shall be referred by a medical practitioner.						
	EVIDENCE OF COMPLIANCE	1.	Facility policy on referral to allied health services by medical practitioner				
		2.	Referral letter/referral form written by medical practitioner				
		3.	All patients/clients are registered in the manual register book or electronic system.				
		4.	Patient's medical record				
	Facility Comments:						
17H.3.1.7	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.						
	EVIDENCE OF COMPLIANCE	1.	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.				
	Facility Comments:						

SURVEY ITEM & SELF-ASSESSMENT					
TOPIC 17H.4:		FACILITIES AND EQUIPMENT			
STANDARD 17H.4.1		Appropriate, safe and adequate facilities and equipment are available for the delivery of effective Social Medical Work Services and ensuring patient safety.			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
17H.4.1.1	There are adequate and appropriate facilities and equipment with proper utilisation of space to enable staff to carry out their professional, teaching and administrative functions.				
	EVIDENCE OF COMPLIANCE	1. Adequate and proper utilisation of space.			
		2. Appropriate type of equipment to match the complexity of services.			
		3. Adequate facilities and equipment for safe care. (e.g. access to emergency cart, hand washing facilities, etc)			
		4. Easy access and clear exit routes			
		5. Absence of overcrowding			
	Facility Comments:				
17H.4.1.2	There shall be a room easily accessible and with conducive environment to conduct biopsychosocial assessment in privacy and to protect confidentiality of the patient.				
	EVIDENCE OF COMPLIANCE	1. Separate room with conducive environment in the Medical Social Officer's office/ ward/ Emergency Services to conduct biopsychosocial assessment in privacy and to protect confidentiality of the patient.			
	Facility Comments:				
17H.4.1.3	There is evidence that the facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Planned Preventive Maintenance records such as schedule, stickers, etc.				
		2. Planned Replacement Programme where applicable				
		3. Complaint records				
		4. Asset inventory				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT					
TOPIC 17H.5:		<u>SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES</u>			
<u>STANDARD 17H.5.1</u>		<i>The Head of Medical Social Services shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Medical Social Work Services.</i>			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
17H.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Medical Social Work Services. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.				
	EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to			
		2. Records on performance improvement activities.			
		3. Minutes of performance improvement meetings			
		4. Performance improvement studies			
		5. Records on innovation if available			
	Facility Comments:				
17H.5.1.2	The Head of Medical Social Work Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement to appropriate individual/personnel within the respective services.				
	EVIDENCE OF COMPLIANCE	1. Minutes of meetings			
		2. Letter of assignment of responsibilities			
		3. Job description			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17H.5.1.3	The Head of the Medical Social Work Services shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility.				
	Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.				
	EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:			
		a) Training of staff			
		b) Policy on incident reporting			
		c) Methodology of incident reporting			
		d) Register/records of incidents			
		2. Completed incident reports			
		3. Root Cause Analysis			
		4. Corrective and preventive action plans			
		5. Remedial measure			
	6. Minutes of meetings				
	7. Acknowledgment by Head of Service and PIC/Hospital Director				
	8. Feedback given to staff regarding incident reporting.				
Facility Comments:					
17H.5.1.4 CORE	There is tracking and trending of specific performance indicators not limited to but at least two (2) of the following:				
	a) percentage of early response time taken within two (2) working days from the date of referral (Target: 95%)				
	b) percentage of cases referred to the referral agencies within seven (7) working days after social intervention complete (target: 80%)				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored.				
		2. Records on tracking and trending analysis.				
		3. Remedial measures taken where appropriate.				
	Facility Comments:					
17H.5.1.5	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.					
	EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff.				
		2. Evidence of feedback via communication on results of performance improvement activities through continuing education activities/meetings.				
		3. Minutes of service/unit meetings				
	Facility Comments:					
17H.5.1.6	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.					
	EVIDENCE OF COMPLIANCE	1. Documentation on performance improvement activities and performance indicators.				
		2. Policy statement on anonymity on patients and providers involved in performance improvement activities.				
	Facility Comments:					

SERVICE SUMMARY	
SURVEYOR SUMMARY:	
OVERALL RATING:	
OVERALL RISK:	

SURVEY ITEM & SELF-ASSESSMENT	
SERVICE STANDARD 17I : ALLIED HEALTH PROFESSIONAL SERVICES – COUNSELLING PSYCHOLOGY SERVICES	
	<u>PREAMBLE</u> <i>Counselling Psychology Services shall offer a standard of counselling for promotion of mental health and wellness outreach to inpatients, outpatients, staff and the community a safe, efficient, effective and caring manner. Counselling Psychology Services shall be organized, directed and coordinated with other services in the healthcare facility/community. Counseling Psychology services help people with physical, emotional and mental health to improve their sense of well-being, alleviate feelings of distress and resolve crisis.</i> <i>Counseling Psychology services are provided by :</i> <i>1. Psychology Officer (Counseling) who are registered with the Malaysian Board of Counselor (Act 580) and appointed by government of Malaysia</i> <i>2. Non-registered Psychology Officer (Counseling) appointed by government of Malaysia:</i>
<u>TOPIC 17I.1:</u> <u>STANDARD 17I.1.1</u>	<u>ORGANISATION AND MANAGEMENT</u> <i>The Counselling Psychology Services shall be organized and administered to provide services to clients in efficient, effective and caring manner. It shall be coordinated with other relevant services in accordance with accepted standards of practice.</i> <i>The role of counselling services is to support the holistic care of reducing the risk factors of mental health and promote psychological well-being. In some instances, the Psychology Officers (Counseling) shall also give intervention, consultation, psychoeducation, and guidance.</i>

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
17I.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Counselling Psychology Services are clearly documented and measurable that indicates safety, quality and clients centred care. These reflect the roles and aspirations of the service and the needs of the clients. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.				
		2. Goals and objectives of the Counselling Psychology Services in line with the Facility statements are available, endorsed and dated.				
		3. Evidence of planned reviews of the above statements.				
		4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)				
		5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.				
	Facility Comments:					
171.1.1.2 CORE	There is an organisation chart which: a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head of Counselling Psychology Services, consultants, treatment practitioners and staff of Counselling Psychology Services; b) is accessible to all staff and clients; c) includes off-site services if applicable; d) is revised when there is a major change in any of the following: i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns.					
	EVIDENCE OF COMPLIANCE	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head of Counselling Psychology Services, consultants, treatment practitioners and staff of Counselling Psychology Services.				
		2. Organisation chart of the service is endorsed, dated and accessible.				
		3. The Organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
171.1.1.3 CORE	The Governing Body shall ensure that Counselling Psychology Services are organised in such a way as to: a) facilitate the provision of Counselling Psychology services to clients in the facility in a safe and conducive environment, efficient, effective and caring manner and with due regards for the needs, dignity and privacy of clients and confidentiality of their personal information; b) assure continuity of care; c) address the professional needs of the Counselling Psychology staff; d) ensure the relevant staff are involved in the formulation of policies and procedures concerning clients care appropriate to the scope of services of the Facility.				
	EVIDENCE OF COMPLIANCE	1. The Counselling Psychology Services is organised to cover activities but not limited to items (a) to (d) through:			
		a) work assignment schedule to ensure service provision;			
		b) competent staffing level to provide the necessary service;			
		c) record on continuity of care in client's treatment record;			
		d) Professional Development Plan.			
		2. Services provided ensure privacy and confidentiality:			
		a) individual counselling room;			
		b) group counselling room;			
		c) documented client record and summary progress report.			
Facility Comments:					
171.1.1.4	Regular staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Counselling Psychology Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes are accessible, disseminated and acknowledged by the staff.				
		2. Attendance list of members with adequate representatives of the service.				
		3. Frequency of meetings as scheduled.				
		4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).				
	Facility Comments:					
171.1.1.5	The Head of Counselling Psychology Services is involved in the planning, justification and management of the budget and resource utilisation of the services.					
	EVIDENCE OF COMPLIANCE	1. Minutes of Facility-wide management meeting				
		2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service.				
		3. Approved budget and resources.				
	Facility Comments:					
171.1.1.6	The Head of Counselling Psychology Services is involved in the appointment and/OR assignment of the staff.					
	EVIDENCE OF COMPLIANCE	1. Records on staff interview (if applicable)				
		2. Appointment/assignment letter of Head of Service				
		3. Job description of Head of Service				
		4. Records on staff deployment				
		5. Duty roster				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
171.1.1.7	Appropriate statistics and records shall be maintained in relation to the provision of Counselling Psychology Services and used for managing the services and clients care purposes. All client's treatment records shall be kept according to relevant regulation.				
	EVIDENCE OF COMPLIANCE	1. Policy on keeping client's treatment records			
		2. Records are available but not limited to the following:			
		a) workload/census;			
		b) annual report;			
		c) accident/incident reports;			
		d) staffing number and staff profile;			
		e) staff training records;			
		f) data on performance improvement activities, including performance indicators.			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT								
TOPIC 171.2		<u>HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT</u>						
STANDARD 171.2.1		<i>The Counselling Psychology Services shall be directed and adequately staffed by qualified and experienced staff to achieve the goals and objectives of the Counselling Psychology Services and ensure continuing education and professional development.</i>						
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS				
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING			
171.2.1.1 CORE	The Head and staff of the Counselling Psychology Services shall be individuals qualified by education, training, experience and certification to commensurate with the requirements of the various positions. Staff providing Counselling Psychology Services shall be a registered counsellor and shall have a valid Professional Practicing Certificate. Psychology Officer appointed by Hospital Director to conduct Counselling Psychology services.							
	EVIDENCE OF COMPLIANCE	1. Records on credentials of Head of Service and staff required to fill up the posts within the service and registration (Annual Practicing Certificate)						
		2. Appointment/assignment letters						
		3. Certification						
		4. Training and competency records						
	Facility Comments:							
171.2.1.2	The authority, responsibilities and accountabilities of the Head of Counselling Psychology Services are clearly delineated and documented.							
	EVIDENCE OF COMPLIANCE	1. Appointment letter for Head of Service.						
		2. Description of duties and responsibilities.						
	Facility Comments:							

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
171.2.1.3 CORE	Sufficient numbers of Psychology Officer (Counselling) and support staff with appropriate qualifications are employed to meet the need of the services.							
	EVIDENCE OF COMPLIANCE	1. Number of Psychology Officer (Counselling) and qualification should commensurate with workload.						
		2. Staffing pattern						
		3. Duty roster						
		4. Census and statistics						
	Facility Comments:							
171.2.1.4	There are written and dated specific job descriptions for all categories of staff that include: a) qualifications, training, experience and certification required for the position; b) licensure; c) lines of authority; d) accountability, functions and responsibilities; e) reviewed when required and when there is a major change in any of the following: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations.							
	EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e).						
		2. Job description includes specialisation skills and scope of work which include:						
		a) individual counselling;						
		b) group counselling;						
		c) family counselling;						
		d) consultation.						
		3. The job description is acknowledged by the staff and signed by the Head of Service and dated.						

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	Facility Comments:				
171.2.1.5	Personnel records on training, staff development, leave and others are maintained for every staff. Note: Staff personal record may be kept in Human Resource Department as per Facility policy.				
	EVIDENCE OF COMPLIANCE	1. Staff personal records include:			
		a) staff biodata;			
		b) qualification and experience;			
		c) evidence of current registration;			
		d) training record;			
		e) competency record and privileging;			
		f) leave record;			
		g) confidentiality agreement.			
	Facility Comments:				
171.2.1.6	There is a structured orientation programme where new staff are briefed on their services, operational policies and relevant aspects of the Facility to prepare them for their roles and responsibilities.				
	EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme.			
		2. Records on structured orientation programme			
		3. Orientation Brief			
		4. List of attendance			
	Facility Comments:				
171.2.1.7	There is evidence of training needs assessment and staff development plan which provides the knowledge and skills required for staff to maintain competency in their current positions and future advancement.				
	EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and gaps identified.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		2. A staff development plan based on training needs assessment is available.				
		3. Training schedule/calendar is in place.				
		4. Training module				
	Facility Comments:					
171.2.1.8	There are continuing education activities for staff to pursue professional interests and to prepare for current and future changes in practice.					
	EVIDENCE OF COMPLIANCE	1. Continuing education activities and schedule				
		2. Contents of training programme, i.e. psychological testing example TAJMA, Myers-Briggs Type Indicator (MBTI), etc				
		3. Training records on continuing education activities are kept and maintained for each staff.				
		4. Certificate of attendance/degree/post graduate training.				
	Facility Comments:					
171.2.1.9	Staff receive appraisal of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.					
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff is Completed upon probationary period and as an annual exercise.				
	Facility Comments:					
171.2.1.10	In a Facility where education programs are conducted, the Facility shall ensure that there are sufficient skilled trained staff to provide clinical supervision/ internship of students.					
	EVIDENCE OF COMPLIANCE	1. Letter of appointment – Local Preceptor/ Clinical Instructor.				
		2. Memorandum of Understanding/ Agreement with training institution				
		3. Adequate number Senior Psychology Officer (Counselling) to students				
		4. Qualification and training records of local preceptor				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	5. Clinical Student Log Book				
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT				
TOPIC 17I.3:	<u>POLICIES AND PROCEDURES</u>			
STANDARD 17I.3.1	<i>There are written and dated policies and procedures for all activities of the Counselling Psychology Services. These policies and procedures reflect current standards of Counselling Psychology services and practice, relevant regulations, statutory requirements, and the goals and objectives of the Counselling Psychology Services.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
17I.3.1.1 CORE	There are written policies and procedures for the Counselling Psychology Services which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated. There is a mechanism for and evidence of a periodic review at least once in every three years.			
	EVIDENCE OF COMPLIANCE			
	1. Documented policies and procedures for the service.			
	2. Policies and procedures are consistent with regulatory requirements and current standard practices, i.e. Counsellor Act 580 or Standard Operating Procedure (SOP) Counselling Psychology Services, MOH			
	3. Evidence of periodic review of policies and procedures.			
	4. The policies and procedures are endorsed and dated.			
	Facility Comments:			
17I.3.1.2 CORE	Policies and procedures are developed by a committee in collaboration with staff, treatment practitioners, management and where required with other external service providers and with reference to relevant sources involved and a documentation of counselling and psychological care plan, which includes: a) assessment; b) diagnosis c) intervention; d) monitoring and evaluation; e) Consultation with the treatment practitioner; and shall be recorded in the clients treatment record.			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	Cross departmental collaboration is practiced in developing relevant policies and procedures where applicable.				
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures that cover items (a) to (e).			
		2. Minutes of meeting with evidence of cross reference with other departments/relevant sources.			
		3. Documented cross departmental policies			
		4. Clinical documentation in client's treatment records includes clear record of assessment; diagnosis; intervention; monitoring and evaluation.			
	Facility Comments:				
171.3.1.3	There shall be a policy to address emergency resuscitation in the event of any life threatening situations and the Emergency Resuscitation Team can be alerted immediately, e.g. Code Blue, Code Grey, Emergency alert for example for disaster case, Trauma and Crisis Cases is available.				
	EVIDENCE OF COMPLIANCE	1. Policy for Code Blue and Code Grey within the service area.			
		2. Flow chart and contact number of Code Blue and Code Grey made available and accessible.			
	Facility Comments:				
171.3.1.4	Current policies and procedures are communicated to all staff.				
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings			
		2. Circulation list and acknowledgement			
	Facility Comments:				
171.3.1.5 CORE	There is evidence of compliance with policies and procedures and standards of practice.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Compliance with policies and procedures through:				
		a) interview of staff on practices;				
		b) verify with observation on practices;				
		c) results on audit on practices;				
		d) practices in line with established policies and procedures.				
	Facility Comments:					
171.3.1.6	Clients seeking consultation/treatment to the Counselling Psychology Services shall be referred by a Medical Practitioner. Note Staffs are allowed to walk in for counseling sessions by self-referral.					
	EVIDENCE OF COMPLIANCE	1. Facility policy on referral to allied health services by Medical Practitioner				
		2. Referral letter/referral form written by Medical Practitioner				
		3. All client are registered in the manual register book or electronic system.				
		4. Clients treatment record				
	Facility Comments:					
171.3.1.7	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.					
	EVIDENCE OF COMPLIANCE	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT				
TOPIC 171.4:	<u>FACILITIES AND EQUIPMENT</u>			
STANDARD 171.4.1	<i>Appropriate, safe and adequate facilities and equipment are available for the delivery of effective Counselling Psychology Services and ensuring clients safety.</i>			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT
				SURVEYOR RATING
171.4.1.1 CORE	There is appropriate access to the facility, adequate facilities and equipment, psychological testing and educational tools with proper utilization of space to enable staff to carry out their professional, teaching and administrative functions.			
EVIDENCE OF COMPLIANCE	1. Adequate and proper utilization of space.			
	a) individual counselling room			
	b) group counselling room			
	c) adequate storage space (locked cabinet/storage)			
	2. Appropriate type of equipment, psychological testing and educational tools to match the complexity of services.			
	3. Adequate facilities and equipment for safe care and access to :			
	a) panic button,			
	b) hand washing facilities , emergency cart			
	4. Easy access and clear exit routes			
	5. Absence of overcrowding			
	Facility Comments:			
171.4.1.2 CORE	There shall be a conducive room; easily accessible, equipped with counselling and psychological assessment and educational tools to conduct the counselling process in privacy to the clients.			
EVIDENCE OF COMPLIANCE	1. Suitable rooms for counseling session (such as sofa, coffee table, air condition and etc)			
	2. List of Psychological Assessment and educational tools			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	Facility Comments:				
171.4.1.3	There is documented evidence that psychological instruments and assessment comply where applicable, with relevant standards.				
	EVIDENCE OF COMPLIANCE	1. Psychological assessment and educational tools used			
	Facility Comments:				
171.4.1.4	There is evidence that the Facility has a comprehensive maintenance program such as planned preventive maintenance to ensure the facilities and equipment are in good working order.				
	EVIDENCE OF COMPLIANCE	1. Planned Preventive Maintenance records such as schedule, stickers, etc.			
		2. Planned Replacement Programmed where applicable			
		3. Complaint records			
		4. Asset inventory			
	Facility Comments:				
171.4.1.5	Where specialized equipment, psychological assessment and educational tools are used, there is evidence that only staff who are trained and authorized by the Facility operate such equipment.				
	EVIDENCE OF COMPLIANCE	1. License and certificate of the user of psychological assessment and educational tools			
		2. User training records			
		3. Competency assessment record			
		4. List of staff trained and authorized to psychological assessment and educational tools			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT						
<u>TOPIC 17I.5:</u>		<u>SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES</u>				
<u>STANDARD 17I.5.1</u>		<i>The Head of Counselling Psychology Services shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Counselling Psychology Services.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17I.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Counselling Psychology Services. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.					
	EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored.				
		2. Records on tracking and trending analysis.				
		3. Remedial measures taken where appropriate				
	Facility Comments:					
7I.5.1.2	The Head of Counselling Psychology Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement to appropriate individual/personnel within the respective services.					
	EVIDENCE OF COMPLIANCE	1. Minutes of meetings				
		2. Letter of assignment of responsibilities				
		3. Job description				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	Facility Comments:				
171.5.1.3	The Head of Counselling Psychology Services shall ensure that the staff are trained and complete incident which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In-Charge (PIC) of the Facility. Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.				
	EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:			
		a) Training of staff			
		b) Policy on incident reporting			
		c) Methodology of incident reporting			
		d) Register/records of incidents			
		2. Completed incident reports			
		3. Root Cause Analysis			
		4. Corrective and preventive action plans			
		5. Remedial measure			
		6. Minutes of meetings			
		7. Acknowledgment by Head of Service and PIC/Hospital Director			
		8. Feedback given to staff regarding incident reporting.			
	Facility Comments:				
171.5.1.4 CORE	There is tracking and trending of specific performance indicators not limited to but at least two (2) of the following: a) Percentage of new case given counseling psychology services within 3 working days b) Percentage of clients achieved their counseling goal.				
	EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored.			
		2. Records on tracking and trending analysis.			
		3. Remedial measures taken where appropriate			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	Facility Comments:				
171.5.1.5	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.				
	EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff.			
		2. Evidence of feedback via communication on results of performance improvement activities through continuing education activities/meetings.			
		3. Minutes of service/unit/committee meetings			
	Facility Comments:				
171.5.1.6	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of Medical Practitioners, staff and clients is preserved.				
	EVIDENCE OF COMPLIANCE	1. Documentation on performance improvement activities and performance indicators.			
		2. Policy statement on anonymity on clients and providers involved in performance improvement activities.			
	Facility Comments:				

SERVICE SUMMARY	
SURVEYOR SUMMARY:	
OVERALL RATING:	
OVERALL RISK:	

SURVEY ITEM & SELF-ASSESSMENT				
SERVICE STANDARD 17J : ALLIED HEALTH PROFESSIONAL SERVICES – CLINICAL PSYCHOLOGY SERVICES				
	PREAMBLE <i>Clinical Psychology Services shall offer recognition, assessment, diagnosis, treatment, rehabilitation and prevention of cognitive, emotional, and behavioural dysfunction and learning disorder to improve clinical symptoms and enhance the subjects wellbeing, mental health and life functioning using evidence based and scientist- practitioner model as well as utilizing clinical application of psychological principle.</i> THE SERVICES ARE PART OF A MULTIDISCIPLINARY TEAM FOR PSYCHOLOGICAL READJUSTMENT AND RESTORATION TO PSYCHOLOGICAL FITNESS.			
TOPIC 17J.1: STANDARD 17J.1.1	ORGANISATION AND MANAGEMENT <i>The Clinical Psychology Services shall be organised and administered by trained, qualified, and registered Clinical Psychologists to provide clinical psychological services to outpatients, inpatients and the community with respect, competence, responsibility and integrity. The services shall be coordinated with other relevant clinical services in accordance with accepted standards of practice. In some instances, these services may be provided from and to other referral centers.</i>			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT
				SURVEYOR RATING
17J.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Clinical Psychology Services are clearly documented and measurable that indicates safety, quality and patient person-centred approach care. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff by the organisation or designated service.			
	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.		
		2. Goals and objectives of the Clinical Psychology Services in line with the Facility statements are available, endorsed and dated.		

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		3. Evidence of planned reviews of the above statements.				
		4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc).				
		5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.				
	Facility Comments:					
17J.1.1.2 CORE	There is an organisation chart which: a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head of Clinical Psychology Services, consultants, medical practitioners and staff of Clinical Psychology Services; b) is accessible to all staff and clients; c) includes off-site services if applicable; d) is revised when there is a major change in any of the following: i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns.					
	EVIDENCE OF COMPLIANCE	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head of the Clinical Psychology Services, consultants, medical practitioners and staff of the Clinical Psychology Services.				
		2. Organisation chart of the service is endorsed, dated and accessible.				
		3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
17J.1.1.3	The Governing Body shall ensure that Clinical Psychology Services are organised in such a way as to: a) facilitate the provision of clinical psychology services in the Facility with respect, competence, responsibility and integrity for the needs of the patients/clients and in confidentiality of their personal information; b) assure continuity of care c) practise person-centred approach in patient care to maintain and improve on health and well-being d) ensure that the Clinical Psychologists are involved in the formulation of policies and procedures concerning patient care appropriate to the scope of services of the facility. c) address the professional needs development of the Clinical Psychologist;					
	EVIDENCE OF COMPLIANCE				1. The Clinical Psychology Services is organised to cover activities but not limited to items (a) to (d) through:	
					a) work assignment schedule to ensure service provision;	
					b) competent staffing level to provide the necessary	
					c) record on continuity of care in patient's medical treatment record;	
					d) Professional Development Plan.	
					2. Services provided ensure person-centred treatment, privacy and confidentiality:	
					a) sessions are conducted in a safe and private manner;	
					b) (explained and) signed informed consent document.	
					3. Relevant Policies and Acts are available, i.e. Psychiatry and Mental Health Policy, Allied Health Act 774	
Facility Comments:						
17J.1.1.4	Regular staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Clinical Psychology Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes are accessible, disseminated and acknowledged by the staff.				
		2. Attendance list of members with adequate representatives of the service.				
		3. Frequency of meetingsas scheduled.				
		4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).				
	Facility Comments:					
17J.1.1.5	The Head of Clinical Psychology Services is involved in the planning, justification and management of the budget and resource utilisation of the services.					
	EVIDENCE OF COMPLIANCE	1. Minutes of Facility-wide management meeting				
		2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc)				
		3. Approved budget and resources.				
	Facility Comments:					
	17J.1.1.6	The Head of Clinical Psychology Services in the organisation is involved in the appointment and/OR assignment of the staff.				
EVIDENCE OF COMPLIANCE		1. Records on staff interview (if applicable)				
		2. Appointment/assignment letter of Head of Service				
		3. Job description of Head of Service				
		4. Records on staff deployment				
		5. Duty roster				
Facility Comments:						

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17J.1.1.7	Appropriate statistics and records shall be maintained in relation to the provision of Clinical Psychology Services and used for monitoring and enhancing the services and patient care purposes.					
	EVIDENCE OF COMPLIANCE	1. Policy on keeping patients medical records				
		2. Records are available but not limited to the following:				
		a) workload/census;				
		b) annual report;				
		c) accident/incident reports;				
		d) staffing number and staff profile;				
		e) staff training records;				
	f) data on performance improvement activities, including performance indicators					
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT							
TOPIC 17J.2		<u>HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT</u>					
STANDARD <u>17J.2.1</u>		<i>The Clinical Psychology Services shall be directed and adequately staffed by qualified and experienced staff to achieve the goals and objectives of the Clinical Psychology Services and ensure continuing education and professional development.</i>					
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17J.2.1.1 CORE	The Head and staff of the Clinical Psychology Services shall be individuals qualified by education, training, experience and certification to commensurate with the requirements of the various positions.						
	The Clinical Psychology Services are provided by individuals with a minimum Masters in Clinical Psychology and have a valid Professional Practising Certificate.						
	EVIDENCE OF COMPLIANCE	1. Records on credentials of Head of Clinical Psychology Service and staff required to fill up the various posts within the service and registration (Annual Practising Certificate)					
		2. Appointment/assignment letters					
		3. Certification					
		4. Training and competency records					
	Facility Comments:						
17J.2.1.2	The authority, responsibilities and accountabilities of the Head of Clinical Psychology Services are clearly delineated and documented.						
	EVIDENCE OF COMPLIANCE	1. Appointment/assignment letter for Head of Service.					
		2. Description of duties and responsibilities.					
	Facility Comments:						

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17J.2.1.3 CORE	Sufficient numbers of competent clinical psychologists with appropriate qualifications and support staff are employed to meet the need of the services.				
	EVIDENCE OF COMPLIANCE	1. Number of competent clinical psychologists and support staff commensurate with workload as per Workload Staffing Indicator (WISN) of the Ministry of Health			
		2. Staffing pattern			
		3. Duty roster			
		4. Census and statistics			
	Facility Comments:				
17J.2.1.4	There are written and dated specific job descriptions for all categories of staff that include: a) qualifications, training, experience and certification required for the position; b) lines of authority; c) accountability, functions and responsibilities; d) reviewed when required and when there is a major change in any of the following: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations. e) administrative and clinical functions.				
	EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e).			
		2. Job description includes specialisation skills			
		3. The job description is acknowledged by the staff and signed by the Head of Service and dated.			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
17J.2.1.5	Personnel records on training, staff development, leave and others are maintained for every staff. Note: <i>Staff personal record may be kept in Human Resource Department as per Facility policy.</i>			
	EVIDENCE OF COMPLIANCE			
	1. Staff personal records include:			
	a) staff biodata;			
	b) qualification and experience;			
	c) training record;			
	d) competency record and privileging;			
	e) leave record;			
	f) confidentiality agreement.			
	Facility Comments:			
17J.2.1.6	There is a structured orientation programme where new staff are briefed on their services, operational policies and relevant aspects of the Facility to prepare them for their roles and responsibilities.			
	EVIDENCE OF COMPLIANCE			
	1. Policy requiring all new staff to attend a structured orientation programme.			
	2. Records on structured orientation programme/Competency training, Mind Transformation Programme (PTM)			
	3. Orientation Brief			
	4. List of attendance/certificate			
	Facility Comments:			
17J.2.1.7	There is evidence of training needs assessment and staff development plan which provides the knowledge and skills required for staff to maintain competency in their current positions and future advancement.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and gaps identified.				
		2. A staff development plan based on training needs assessment is available.				
		3. Training schedule/calendar is in place.				
		4. Training module				
	Facility Comments:					
17J.2.1.8	There are continuing education activities for staff to pursue professional interests and to prepare for current and future changes in practice.					
	EVIDENCE OF COMPLIANCE	1. Continuing education activities and schedule				
		2. Contents of training programme				
		3. Training records on continuing education activities are kept and maintained for each staff.				
		4. Certificate of attendance/degree/post basic training.				
	Facility Comments:					
17J.2.1.9	Staff receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.					
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff is completed upon probationary period and as an annual exercise				
	Facility Comments:					
17J.2.1.10	In a Facility where education programmes are conducted, the Facility shall ensure that there are sufficient skilled trained staff to provide clinical supervision/internship of students.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Facility Usage Guideline, Ministry of Health Malaysia (<i>Garis Panduan Penggunaan Fasilitas KKM</i>)				
		2. Letter of appointment – Local Preceptor/ Clinical Instructor.				
		3. Memorandum of Understanding with training institution				
		4. Adequate number of clinical instructor to students				
		5. Qualification and training records of local preceptor				
		6. Clinical Student Log Book				
	Facility Comments:					
17J.2.1.11	The standard require that organisations have arrangement for the: a) promotion of staff well-being b) resolution of workplace issues					
	EVIDENCE OF COMPLIANCE	1. The promotion of staff well-being may involve:				
		a) Procedures to promote well-being, e.g. stress management, workload monitoring, management of work-life balance, healthy lifestyle programs				
		b) staff being provided with appropriate supervision, support and advise.				
		2. The resolution of workplace issues may involve:				
		a) measures to protect staff against violence, bullying and sexual harassment				
		b) clear procedures for the effective management of underperformance				
	Facility Comments:					

SURVEY ITEM &SELF-ASSESSMENT					
<u>TOPIC 17J.3:</u>		<u>POLICIES AND PROCEDURES</u>			
<u>STANDARD</u> <u>17J.3.1</u>		<i>There are written and dated policies and procedures for all activities of the Clinical Psychology services. These policies and procedures reflect current standards of Clinical Psychology Services and practice, relevant regulations, statutory requirements, and the goals and objectives of the Clinical Psychology Services.</i>			
				SURVEYOR FINDINGS	
			SELF RATING		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	
				SURVEYOR RATING	
17J.3.1.1 CORE	There are written policies and procedures for the Clinical Psychology Services which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated. There is a mechanism for and evidence of a periodic review at least once in every three years.				
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for the service include:			
		a) Written Policy and Procedure appropriate to services and facilities e.g. Psychiatry and Mental Health Policy, Palliative Care Policy			
		b) Facility Usage Guideline, Ministry of Health Malaysia (<i>Garis Panduan Penggunaan Fasilitas</i>)			
		c) <i>Pelan Pengurusan Operasi Profesion Psikologi Klinikal</i>			
		d) <i>Standard Operation Procedure Profesion Psikologi Klinikal</i>			
		e) <i>Allied Health Act 774?</i>			
		2. Policies and procedures are consistent with regulatory requirements and current standard practices.			
		3. Evidence of periodic review of policies and procedures.			
	4. Policies and procedures are updated, endorsed and dated.				
Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
17J.3.1.2 CORE	Policies and procedures are developed in collaboration with staff, medical practitioners, management, where required with other external service providers and with reference to relevant sources involved and shall include documentation of clinical psychological care plan which includes: a) assessment plan appropriate for each patient; - formulation which is the summation and integration of the knowledge that is acquired by the assessment process. This will draw on psychological theory and research to provide a framework for describing a patient's problem or needs; b) treatment plan for patient to achieve planned outcome; c) monitoring of the patient to assess the outcome of patient care; d) planning follow up, including termination plans; e) guidelines for obtaining every patient's or caregiver's informed consent. Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.				
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures. that cover items (a) to (e)			
		2. Minutes of meeting with evidence of cross reference with other departments/relevant sources.			
		3. Documented cross departmental policies			
		4. Clinical Documentation in patient's medical records pertaining to patient's assessment report and care plan.			
		5. Standard Operation Procedure of the Profession of Clinical Psychology			
		6. Informed consent document			
	Facility Comments:				
17J.3.1.3	There shall be a policy to address emergency resuscitation in the event of any life threatening situations and the Emergency Resuscitation Team can be alerted immediately, e.g. Code Blue.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	EVIDENCE OF COMPLIANCE	1. There is an emergency exit for staff.					
		2. There is mechanical bell/device for security alert.					
		3. There are safety guideline and policy available.					
		4. Policy for Code Blue within the service area					
		5. Flow chart and contact number of Code Blue made available and accessible.					
	Facility Comments:						
17J.3.1.4	Current policies and procedures are communicated to all staff.						
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings					
		2. Circulation list and acknowledgement					
	Facility Comments:						
17J.3.1.5 CORE	There is evidence of compliance with policies and procedures and standards of practice.						
	EVIDENCE OF COMPLIANCE	1. Compliance with policies and procedures through:					
		a) interview of staff on practices;					
		b) verify with observation on practices;					
		c) results on audit on practices;					
		d) staff acknowledgement on written document;					
		e) practices in line with established policies and procedures.					
	Facility Comments:						

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
17J.3.1.6	All referrals to the Clinical Psychology Services shall be referred by a medical practitioner .					
	EVIDENCE OF COMPLIANCE	1. Facility policy on referral to allied health services by medical practitioner/specialist through written or digital referral format				
		2. Patient's medical record				
	Facility Comments:					
17J.3.1.7	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.					
	EVIDENCE OF COMPLIANCE	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference, e.g. Psychiatry and Mental Health Act and Occupational Safety and Health Act 1994.				
	Facility Comments:					

SURVEY ITEM &SELF-ASSESSMENT							
TOPIC 17J.4:		FACILITIES AND EQUIPMENT					
STANDARD 17J.4.1		Updated, safe and adequate facilities and equipment are available for the delivery of effective Clinical Psychology Services and ensuring patient safety.					
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS			
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
17J.4.1.1	There is appropriate access to the facility, adequate facilities and equipment with proper utilisation of space to enable staff to carry out their professional, teaching and administrative functions.						
	EVIDENCE OF COMPLIANCE	1. Adequate and proper utilisation of space:					
		2. Adequate storage space					
		3. Appropriate type of equipment to match the complexity of services.					
		4. Adequate facilities and equipment at patient care area for safe care:					
		a) defibrillators, emergency cart, hand washing facilities etc					
		b) individualised and conducive room to ensure privacy;					
		c) adequate lighting and minimal noise.					
		5. Easy access and clear exit routes					
		6. Absence of overcrowding					
	Facility Comments:						
17J.4.1.2 CORE	There shall be a room easily accessible, equipped with clinical psychology facilities and equipment/instruments to conduct clinical psychological assessment process in privacy to the patients.						
	EVIDENCE OF COMPLIANCE	1. Standardized equipment (cognitive, personality, etc) for all age range of patients.					
		2. Equipments are replaced and updated accordingly.					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	3. There is record of registration of clinical psychology facilities and equipment/instruments.				
	Facility Comments:				
17J.4.1.3	There is documented evidence that clinical psychological instrument/equipment complies with relevant national/international standards and current statutory requirements.				
	EVIDENCE OF COMPLIANCE				
	1. Testing, commissioning and calibration records (certificates or stickers)				
	2. Certification of instrument/equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as evidence of compliance to the relevant standards and Acts.				
	Facility Comments:				
17J.4.1.4 CORE	There is evidence that the facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.				
	EVIDENCE OF COMPLIANCE				
	1. Planned Preventive Maintenance records such as schedule, stickers, etc.				
	2. Planned Replacement Programme where applicable				
	3. Complaint records				
	4. Asset inventory				
	Facility Comments:				
17J.4.1.5	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by Facility operate such equipment.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	EVIDENCE OF COMPLIANCE	1. User training records for specific psychological equipment/instruments.					
		2. Competency assessment record					
		3. Letter of authorisation					
		4. List of staff trained and authorised to operate specialised equipment					
	Facility Comments:						
17J.4.1.6	Alarm system for emergencies appropriate to patient needs shall be made available.						
	EVIDENCE OF COMPLIANCE	1. Panic button, mechanical device such as phone or bell on site at patient therapy room.					
	Facility Comments:						

SURVEY ITEM &SELF-ASSESSMENT					
<u>TOPIC 17J.5:</u>		<u>SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES</u>			
<u>STANDARD 17J.5.1</u>		<i>The Head of Clinical Psychology Services shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Clinical Psychology Services.</i>			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
17J.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Clinical Psychology Services.The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.				
	EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to (f).			
		2. Records on performance improvement activities.			
		3. Minutes of performance improvement meetings			
		4. Performance improvement studies			
		5. Records on innovation if available			
	Facility Comments:				
17J.5.1.2	The Head of Clinical Psychology Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement to appropriate individual/personnel within the respective services.				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes of meetings 2. Letter of assignment of responsibilities			
	Facility Comments:				
17J.5.1.3	The Head of the Clinical Psychology Services shall ensure that staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility. E.g. treatment-emergent reactions, adverse treatment reaction, aggression Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.				
	EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include: a) Training of staff b) Policy on incident reporting c) Methodology of incident reporting d) Register/records of incidents 2. Completed incident reports 3. Root Cause Analysis 4. Corrective and preventive action plans 5. Remedial measure 6. Minutes of meetings 7. Acknowledgment by Head of Service and PIC/Hospital Director 8. Feedback given to staff regarding incident reporting.			
	Facility Comments:				
17J.5.1.4 CORE	There is tracking and trending of specific performance indicators not limited to but at least two (2) (suges for atleast one of two of the following) of the following: a) percentage of relapse cases (sentinel event) (where applicable) b) percentage of Psychological Assessment Completed within 30 working days				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	(Target :85% 90%) c) Percentage of new patient referred for psychotherapy session receiving first session within 60 working days (target: 80%)				
	EVIDENCE OF COMPLIANCE 1. Specific performance indicators monitored.				
	2. Records on tracking and trending analysis.				
	3. Remedial measures taken where appropriate				
	Facility Comments:				
17J.5.1.5	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.				
	EVIDENCE OF COMPLIANCE 1. Results on safety and performance improvement activities are accessible to staff.				
	2. Evidence of feedback via communication on results of performance improvement activities through continuing education activities/meetings.				
	3. Minutes of service/unit meetings				
	Facility Comments:				
17J.5.1.6	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.				
	EVIDENCE OF COMPLIANCE 1. Documentation on performance improvement activities and performance indicators.				
	2. Policy statement on anonymity on patients and providers involved in performance improvement activities.				
	Facility Comments:				
17J.5.1.7	The Head of Services shall identify the role of Clinical Psychologist in the management of crisis and disaster in accordance to the organisation or				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	department needs and requirement.					
	EVIDENCE OF COMPLIANCE	1. Job description of staff involvement in crisis and disaster menagement.				
		2. Crisis and disaster emergency or contingency plan of the organisation				
	Facility Comments:					

SERVICE SUMMARY	
SURVEYOR SUMMARY:	
OVERALL RATING:	
OVERALL RISK:	

SURVEY ITEM & SELF-ASSESSMENT				
SERVICE STANDARD 18 : PHARMACY SERVICES				
	<u>PREAMBLE</u> <i>The Pharmacy Services shall provide safe and efficient delivery of the following activities:</i> <i>a) evaluation, appraisal and recommendation for selection of pharmaceutical products;</i> <i>b) procurement, storage, distribution and delivery of pharmaceutical products;</i> <i>c) manufacturing and reprocessing of pharmaceutical products;</i> <i>d) drug information, dissemination and patient counseling;</i> <i>e) poison information and advisory services;</i> <i>f) clinical pharmacy services;</i> <i>g) harm reduction therapy services, e.g. Methadone dispensing, counseling on smoking cessation.</i>			
<u>TOPIC 18.1:</u> <u>STANDARD 18.1.1</u>	<u>ORGANISATION AND MANAGEMENT</u> <i>The Pharmacy Services shall be organised and administered to provide efficient pharmaceutical care services including the purchase, distribution, and control of pharmaceutical products; and to disseminate appropriate drug information to the healthcare team and patients of the Facility in accordance with prevailing standards of pharmacy practice.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
18.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Pharmacy Services are clearly documented and measurable. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.					
		2. Goals and objectives of the Pharmacy Services in line with the Facility statements are available, endorsed and dated.					
		3. Evidence of planned reviews of the above statements.					
		4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)					
		5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.					
	Facility Comments:						
18.1.1.2 CORE	There is an organisation chart which: a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head and the staff of Pharmacy Services; b) is accessible to all staff and clients; c) includes off-site services and satellite pharmacies (where applicable); d) is revised when there is a major change in any of the following: i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns. All off-site and satellite pharmacies under the purview of Pharmacy Services shall be included in the main organisation chart.						
EVIDENCE OF COMPLIANCE	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head and staff of Pharmacy Services.						
	2. Organisation chart of the service is endorsed, dated and accessible.						

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	3.	The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).				
	Facility Comments:					
18.1.1.3	Regular staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Pharmacy Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.					
	EVIDENCE OF COMPLIANCE	1. Minutes are accessible, disseminated and acknowledged by the staff.				
		2. Attendance list of members with adequate representatives of the service.				
		3. Frequency of meetings as scheduled.				
		4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).				
		5. .				
	Facility Comments:					
18.1.1.4	The Head of Pharmacy Services is involved in the planning, justification and management of the budget and resource utilisation of the services.					
	EVIDENCE OF COMPLIANCE	1. Minutes of Facility-wide management meeting				
		2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service.				
		3. Approved budget and resources.				
	Facility Comments:					
18.1.1.5	The Head of Pharmacy Services is involved in the appointment and/OR assignment of staff.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	EVIDENCE OF COMPLIANCE	1. Records on staff interview (if applicable)					
		2. Appointment/assignment letter of Head of Service					
		3. Job description of Head of Service					
		4. Records on staff deployment					
		5. Duty roster					
	Facility Comments:						
18.1.1.6	The Head of the Pharmacy Services is responsible in the formulation of all administrative decisions relating to the provision of Pharmacy Services and the use of medicines.						
	EVIDENCE OF COMPLIANCE	1. Job description of Head of Pharmacy Services					
		2. Minutes of meeting					
	Facility Comments:						
18.1.1.7	The Pharmacy Services provides services that include the procurement, distribution, provision of information, and the practice of safety and performance improvement activities of all pharmaceutical products in the Facility.						
	EVIDENCE OF COMPLIANCE	1. Procurement record					
		2. Inventory control record					
		3. Audit report					
		4. Drug information record					
		5. Safety and performance improvement activities					
	Facility Comments:						
18.1.1.8	Specific services provided by the Pharmacy Services shall include, as appropriate, the following:						
	a) dispensing of medicines according to Good Dispensing Practices;						

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	b) clinical pharmacy services include: i) quality use of medicines (dosage, indication for use, efficacy, adverse reactions, drug interaction and food interactions, patient consent for animal origin related medicines that affect their religious beliefs and in terms of legal requirements), where appropriate; ii) total parenteral nutrition; iii) clinical pharmacokinetics services; iv) reconstitution of cytotoxic drugs; c) nuclear medicine services; d) educational services: i) medicines usage and counselling for patients; ii) drugs and drug therapy for medical, nursing, and other staff; iii) poison information and advisory services; iv) continuing education for pharmacy staff. e) manufacturing of pharmaceutical products shall be in accordance with Good Manufacturing Practice (GMP) or Good Preparation Practice (GPP) and guidelines for the following services: i) reconstitution of cytotoxic drugs; ii) preparation of radiopharmaceuticals used in nuclear medicine; iii) preparation of extemporaneous preparations (non-sterile pharmaceutical products that are not stored but issued for immediate use). f) participate in research in pharmacy services to improve medicine related therapy and utilisation; where applicable; g) storage and dispensing of psychotropic substances shall be in accordance with the provisions of Poisons (Psychotropic Substances) Regulations (1989) as in the Third Schedule of the Poisons Act 1952;			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	h) storage and dispensing of dangerous drugs shall be in accordance with the provisions of Dangerous Drugs Act and Regulations (1952).					
	EVIDENCE OF COMPLIANCE	1. Specific services provided by the Pharmacy Services shall include items (a) to (h).				
		2. Availability of standard operating procedures for various specific services provided, which include nuclear medicine and the disposal of radiopharmaceutical substances where applicable.				
		3. List of medicines with animal origin				
		4. Patient consent on animal origin related medicines				
		5. Record of patient counselling				
		6. Record of in-house training conducted by Pharmacy Services.				
		7. Availability of pamphlets/newsletter/bulletin for staff and patient education.				
		8. List of research and publications made available.				
	Facility Comments:					
18.1.1.9	Where there are decentralised sections of the Pharmacy Services, specific objectives are documented.					
	EVIDENCE OF COMPLIANCE	1. Objectives for decentralised sections of the Pharmacy Services are specified and documented.				
	Facility Comments:					
18.1.1.10	Appropriate statistics and records shall be maintained in relation to the provision of Pharmacy Services and used for managing the services and patient care purposes.					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Records are available but not limited to the following:			
		a) workload/census for inpatients and outpatients;			
		b) annual report;			
		c) accident/incident reports;			
		d) staffing number and staff profile;			
		e) staff training records;			
		f) data on performance improvement activities, including performance indicators.			
	Facility Comments:				
18.1.1.11	There shall be a Pharmacy and Therapeutic Committee and the Pharmacy Services shall be represented on multidisciplinary committees where pharmacy matters are discussed. The Terms of Reference of the Pharmacy and Therapeutic Committee shall include to:				
	a) recommend and advise on matters pertaining to the choice of drugs;				
	b) develop and review periodically a formulary or drug list for use in the hospital;				
	c) recommend to the Ethics Committee regarding the standards on the use and control of investigational drugs and research;				
	d) evaluate clinical data concerning new drugs or preparations requested for use in the Facility;				
	EVIDENCE OF COMPLIANCE	e) make recommendations concerning drugs to be stocked on the nursing unit floors and by other services;			
		f) make recommendations concerning drugs for which written orders to continue are necessary;			
		g) make recommendations regarding policies and procedures on the administration of drugs.			
		1. Letters of appointment of members to the Pharmacy and Therapeutic Committee			
		2. Terms of reference include items (a) to (g).			
		3. Regular scheduled meeting			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
		4. Call letter with agenda					
		5. Minutes of meeting acknowledged by the Chairperson of the committee.					
		6. Minutes of meetings circulated to all members – circulation list					
		7. Evidence that relevant outcomes of the meetings are disseminated to relevant staff					
		8. Drug Formulary being established.					
	Facility Comments:						
18.1.1.12	Pharmacy Services maintain good communication with Governing Body, medical professionals and nursing staff through relevant committees and continuing education programmes.						
	EVIDENCE OF COMPLIANCE	1. Minutes of Facility-wide meetings/interdepartmental meetings / committee meetings.					
		2. Interdepartmental policies and procedures					
		3. Continuing medical education programme					
	Facility Comments:						

SURVEY ITEM & SELF-ASSESSMENT							
TOPIC 18.2:		HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT					
Standard 18.2.1		The Pharmacy Services shall be managed by a suitably qualified, experienced and registered pharmacist; and supported by other registered pharmacists, pharmacy assistants and other supporting staff to achieve the objectives of the services.					
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
18.2.1.1 CORE	The Pharmacy Services is directed by the Head who is a registered pharmacist currently registered with the Pharmacy Board of Malaysia and possess a valid licence.						
	EVIDENCE OF COMPLIANCE	1. The Head of Pharmacy Services has a valid professional Annual Practising Certificate (APC) and registered with Pharmacy Board of Malaysia.					
		2. The Head of Pharmacy Services possess a valid licence for manufacturing process (if applicable).					
		3. Appointment/assignment letter					
		4. Job description					
	Facility Comments:						
18.2.1.2	The staffing of the Pharmacy Services is provided by individuals qualified by education, training, experience and certification to commensurate with the requirements of the various positions.						
	EVIDENCE OF COMPLIANCE	1. Records on credentials of Head of Service and staff required to fill up the posts within the service (to match the complexity of the Facility and services) and certification/registration.					
		2. Appointment/assignment letter					
		3. Training and competency records					
	Facility Comments:						

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
18.2.1.3	The authority, responsibilities and accountabilities of the Head of Pharmacy Services are clearly delineated and documented. This includes upholding the laws regulating the practice of pharmacy and the control and distribution of pharmaceuticals products. The Head is also responsible for appropriate liaison with the authorities administering these laws.					
	EVIDENCE OF COMPLIANCE	1. Appointment/assignment letter for Head of Service.				
		2. Description of duties and responsibilities.				
	Facility Comments:					
18.2.1.4	Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the need of the services.					
	EVIDENCE OF COMPLIANCE	1. Number of staff and qualification should commensurate with workload.				
		2. Staffing pattern				
		3. Duty roster				
		4. Census and statistics				
	Facility Comments:					
18.2.1.5	There is a registered pharmacist on duty or on call at all times.					
	EVIDENCE OF COMPLIANCE	1. Availability of duty roster of pharmacy staff.				
	Facility Comments:					

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

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	EVIDENCE OF COMPLIANCE	1. Staff personal records include:					
		a) staff biodata;					
		b) qualification and experience;					
		c) evidence of current registration;					
		d) training record;					
		e) competency record and privileging;					
		f) leave record;					
		g) confidentiality agreement.					
	Facility Comments:						
18.2.1.8	There is a structured orientation programme where new staff are briefed on their services, operational policies and relevant aspects of the Facility to prepare them for their roles and responsibilities.						
	EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme.					
		2. Records on structured orientation programme					
		3. Orientation Brief					
		4. List of attendance					
	Facility Comments:						
18.2.1.9	Staff receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.						
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff is completed upon probationary period and as an annual exercise.					
	Facility Comments:						

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
18.2.1.10	There is evidence of training needs assessment and staff development plan which provides the knowledge and skills required for staff to maintain competency in their current positions and future advancement.					
	EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and gaps identified.				
		2. A staff development plan based on training needs assessment is available.				
		3. Training schedule/calendar is in place.				
		4. Training module				
	Facility Comments:					
18.2.1.11	There are continuing education activities for staff to pursue professional interests and to prepare for current and future changes in practice.					
	EVIDENCE OF COMPLIANCE	1. Training calendar includes in-house/external courses/ workshop/conferences				
		2. Contents of training programme				
		3. Training records on continuing education activities are kept and maintained for each staff including training in life support.				
		4. Certificate of attendance/degree/post basic training.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT					
STANDARD 18.3.1	<u>POLICIES AND PROCEDURES</u> <i>There are documented policies and procedures for the core business of the Pharmacy Services to achieve its goals and objectives. Policies and procedures shall be consistent with the relevant regulations and legal requirements of relevant government agencies.</i>				
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
18.3.1.1 CORE	There are written policies and procedures for the Pharmacy Services which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated. There is a mechanism for and evidence of a periodic review at least once in every three years.				
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for the service.			
		2. Policies and procedures are consistent with regulatory requirements and current standard practices such as Private Healthcare Facilities and Services Act (PHFSA) (1998) and its Regulations (2006), Poison Act 1952 and it Regulations, Dangerous Drug Act 1952 and other relevant guidelines.			
		3. Evidence of periodic review of policies and procedures.			
		4. The policies and procedures are endorsed and dated.			
	Facility Comments:				
18.3.1.2	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved. Cross departmental collaboration is practiced in developing relevant policies and procedures where applicable.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.				
		2. Minutes of meeting with evidence of cross reference with other departments				
		3. Documented cross departmental policies				
	Facility Comments:					
18.3.1.3	Current policies and procedures are communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings				
		2. Circulation list and acknowledgement				
	Facility Comments:					
18.3.1.4 CORE	There is evidence of compliance with policies and procedures.					
	EVIDENCE OF COMPLIANCE	1. Compliance with policies and procedures through:				
		a) interview of staff on practices;				
		b) verify with observation on practices;				
		c) results of audit on practices;				
		d) practices in line with established policies and procedures.				
	Facility Comments:					
18.3.1.5 CORE	There are policies and procedures on ordering and administering of medicines which include:					
	a) incorporation of inpatient and outpatient medication orders into the patient's medical record;					
	b) recording in the patient's medical record for every dose of medicine administered:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	c) keeping accurate and accessible records on medicines supplied and administered to inpatients and outpatients; d) administering of medicines brought into the Facility by patients; e) administering of medicines by patients, where appropriate; f) access to patients' medical records, where appropriate; g) abbreviations where used are in accordance with an approved list by Pharmacy and Therapeutic Committee and endorsed by the Person In Charge (PIC); h) reconstitution, storage, transportation and administration of cytotoxic drugs; i) storage, preparation and transportation of radiopharmaceutical.					
	EVIDENCE OF COMPLIANCE	1. Policies and procedures on ordering and administering of medicines include (a) to (i).				
		2. Prescription patterns				
		3. Medication administration				
		4. Patient medication record				
		5. Records on order, worksheet, preparation, supply and transportation of radiopharmaceuticals.				
		6. Records on order, worksheet, preparation, supply and transportation of cytotoxic drug.				
		7. Drug reconciliation policy				
	Facility Comments:					
18.3.1.6	There are policies and procedures on patient education and counselling which include: a) explanation and instructions by a pharmacist on the use and storage of medications; b) provision of education and counselling as appropriate to patients and their families relating to medicines prescribed.					
EVIDENCE OF COMPLIANCE	1. Policies and procedures on patient education and counselling include (a) and (b).					
	2. Record of counselling					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		3. Evidence of counselling materials (e.g. inhaler placebo, insulin pen, pamphlet, flipchart)				
	Facility Comments:					
18.3.1.7	There are policies and procedures on manufacturing, reprocessing and storage of medicines which include: a) preparation of parenteral nutrition and labelling shall only be done by trained staff; b) intravenous admixtures, reconstitution and preparation of intravenous and other sterile preparations; c) reconstitution, handling and disposal of cytotoxic drugs; d) preparation, handling, quality control and disposal of radiopharmaceuticals; e) repackaging and pre-packaging medicines; f) labelling of medicines; g) storage of all medicines within the Facility with respect to statutory regulations and any other requirements; h) inventory control systems; i) provision of emergency services outside normal pharmacy hours; j) disposal of discontinued, outdated, or unwanted or unused portions of medicines; k) guidelines on spillage and decontamination; l) quality control procedures to be carried out on products prepared in the Pharmacy Services.					
	EVIDENCE OF COMPLIANCE	1. Policies and procedures on manufacturing, reprocessing and storage of medicines to include items (a) to (l).				
		2. Records on implementation process of (a) to (l)				
		3. Drug labels contain name and strength of medication, expiry date, batch number and name of manufacturer.				
		4. List of items/drugs that require refrigeration and temperature monitoring				
		5. Records on medicine movement, regular stock inspection schedule, monitory of expiry date, delivery order, issue notes, first expired first out system of drug stocking, minimum and maximum stock level.				
		6. 24 hours on-call duty schedule				
		7. Disposal records				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	8. Spillage kit and reporting of incident/spillage				
	Facility Comments:				
18.3.1.8	There are policies and procedures on drug and poison information and advisory services. Active dissemination and provision of drug information shall be provided to healthcare professionals.				
	EVIDENCE OF COMPLIANCE	1. Policies and procedures on drug and poison information and advisory services.			
		2. Dissemination of information on drugs and poison (e.g. pamphlet, newsletter, bulletin, circular, continuing medical education)			
	Facility Comments:				
18.3.1.9	There is participation by the pharmacist in the adverse drug reaction reporting system of the Facility. Policies and procedures for Adverse Drug Reaction (ADR) Reporting shall include the method of detection, a mechanism for reporting to the medical practitioner, the pharmacist, the Adverse Drug Reaction Advisory Committee/appropriate internal committee.				
	EVIDENCE OF COMPLIANCE	1. Appropriate committee to discuss the ADR incidents.			
		2. Policies and procedures are in place for ADR reporting			
		3. Sample of ADR reports and dissemination of findings			
	Facility Comments:				
18.3.1.10	There are policies and procedures on monitoring and controlling of sample medicines brought into the Facility.				
	EVIDENCE OF COMPLIANCE	1. Policies and procedures on monitoring and controlling of sample medicines brought into the Facility.			
		2. Records on monitoring and control of sample medicines by Pharmacy Services.			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
18.3.1.11	There are policies and procedures of the Pharmacy Services that address the following: a) dispensing, storage and handling of psychotropic drugs; b) a drug recall procedure; c) security of the Pharmacy Services and storage areas at all times; d) complaints procedure.					
	EVIDENCE OF COMPLIANCE	1. Policies and procedures of the Pharmacy Services that include items (a) to (d).				
	Facility Comments:					
18.3.1.12 CORE	There are documented policies and procedures on prescribing medication that state: a) medicines can only be dispensed by qualified pharmacy personnel based on written order from the medical practitioner; b) electronic prescribing, using an open or closed network if practiced, conform to established conventions with regards to the identity of the prescriber and patient; c) drugs dispensed and administered are based on the original of the medical practitioner's order. Drug orders are not transcribed.					
	EVIDENCE OF COMPLIANCE	1. Policies and procedures include (a) to (c) are available.				
		2. Security access is established for electronic prescribing.				
		3. Records on original prescription.				
		4. Updated sample of doctors' signature for manual prescribing.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
18.3.1.13	Telephone ordering of medicines is limited to exceptional circumstances as defined by regulations and policy of the Facility. If such ordering is accepted, written confirmation by the prescribing medical practitioner shall be obtained within 24 hours.					
	No verbal order for cytotoxic/radiopharmaceutical drugs.					
	EVIDENCE OF COMPLIANCE	1. Policy is in place for telephone ordering.				
		2. Written confirmation by the prescribing medical practitioner is obtained within 24 hours.				
		3. Documentation of the verbal order by the receiving Medical Officer / Nurse in the patient record/ nursing note.				
	Facility Comments:					
18.3.1.14	There is a system for reporting of medication errors, identifying the root cause and corrective action taken to prevent similar errors.					
	EVIDENCE OF COMPLIANCE	1. Standard operating procedures for reporting of medication error				
		2. Sample of medication error report				
		3. Evidence of corrective action taken and dissemination of findings.				
	Facility Comments:					
18.3.1.15	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.				
	Facility Comments:					

SURVEY ITEM &SELF-ASSESSMENT					
TOPIC 18.4:		<u>FACILITIES AND EQUIPMENT</u>			
STANDARD <u>18.4.1</u>		<i>Adequate and appropriate space, equipment and supplies shall be provided for the Pharmacy Services to fulfil its administrative, professional and technical functions according to standards set by the relevant authorities and regulatory requirements. Segregated areas are required for services related to oncology and nuclear medicine.</i>			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
18.4.1.1 CORE		Adequate and safe storage facilities are provided in the Pharmacy Services to ensure that all pharmaceuticals and related substances are kept according to Good Storage Practice guidelines that include: a) protection of the stored materials from all potentially harmful influences, such as undue variations of temperature and humidity, dust and odour, entry of animals, vermin and insects; b) areas shall be sufficiently large, and if necessary, shall have physically separated zones for orderly segregated storage; c) special precautions for the storage of hazardous, sensitive, or dangerous materials such as combustible liquids and solids, pressurised gases or liquids, dangerous and psychotropic drugs and other potent habit-forming substances, highly toxic substances, radiopharmaceutical materials, herbal drugs and remedies; d) special facilities shall be constructed and equipped for materials requiring specific storage conditions relating to temperature, humidity and other physical conditions.			
EVIDENCE OF COMPLIANCE		1. Adequate and safe storage facilities are available and proper utilisation of space.			
		2. Easy access and clear exit routes			
		3. Absence of overcrowding			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		4. Physical inspection on asset to treat and prevent from harmful influences where appropriate, such as air conditioning system, humidifier, vacuum cleaner, air freshener, etc.			
		5. Scheduled pesticides control programme			
		6. Floor plan/Physical layout inspection of storage conditions			
		7. Special precautions for the storage of hazardous, sensitive, or dangerous materials.			
		8. Special facilities for materials requiring specific storage conditions relating to temperature, humidity and other physical conditions.			
	Facility Comments:				
18.4.1.2	Where controlled environmental storage conditions are required, these conditions shall be continually monitored and appropriate corrective action shall be taken where necessary. The desired conditions shall include: a) Temperature Control: The following parameters are complied: i) room temperature, temperature below 30°C; ii) refrigerator, temperature between 2 - 8°C; iii) freezer, temperature not higher than 0°C; iv) ultra low, temperature between -65°C to -95°C. b) Humidity not more than 80%; materials requiring dry or humidity control storage shall be stored in areas where the relative humidity and temperature is maintained within prescribed limits. c) Containment i) Inflammable or corrosive material requires effective ventilation and precautions to handle spillage. ii) Radioactive material requires containment measures like differential pressures.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	EVIDENCE OF COMPLIANCE	1. Temperature monitoring records					
		2. Humidity monitoring records where necessary					
		3. Floor plan and proper signage for containment facilities					
		4. Physical layout inspection to verify storage conditions					
		5. Separate stores and evidence of effective ventilation for inflammable, corrosive and radioactive materials (where necessary).					
	Facility Comments:						
18.4.1.3	Facilities for storing any psychotropic substances shall be locked and unlocked by the person authorised to handle such substances and the keys to such facilities shall be kept by him/her only in accordance with the Poisons (Psychotropic Substances) Regulations (1989).						
	EVIDENCE OF COMPLIANCE	1. List of authorised personnel handling facilities for storing any psychotropic substances					
		2. Records on handing/taking over keys					
		3. On-site inspection on facilities for storing of psychotropic substances					
	Facility Comments:						
18.4.1.4	There are adequate space, facilities, and equipment in the Pharmacy Services for compounding, repackaging, or reprocessing and dispensing of drug products including parenteral, intravenous admixtures, eye-drops, cytotoxic drugs, and radiopharmaceutical preparation where appropriate and with private area for patient counseling session. Designated and properly equipped areas are provided for the following:						
	a) preparation of cytotoxic drugs in accordance with the statutory requirements. The Pharmacy Services shall ensure that cytotoxic waste materials are contained and disposed of in a safe and approved manner;						
	b) preparation for extemporaneous						

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	c) manufacturing of bulk non-sterile products in accordance with statutory regulations and Good Manufacturing Practice (GMP) or Good Preparation Practice (GPP) guidelines if only processing is done;				
	d) preparation of sterile products and intravenous additives in accordance with statutory regulations and Good Manufacturing Practice (GMP) or Good Preparation Practice (GPP) guidelines depending on the services provided;				
	e) preparation of radiopharmaceuticals in accordance with statutory regulations and Good Preparation Practice (GPP) guidelines;				
	f) dispensing counter				
	g) counseling area/room				
	EVIDENCE OF COMPLIANCE	1. Physical layout inspection to verify the following:			
		a) Adequate space, facilities, and equipment for compounding, repackaging, or reprocessing and dispensing of drug products including parenteral, intravenous admixtures, eye-drops, cytotoxic drugs, and radiopharmaceutical preparation.			
b) Designated and properly equipped areas for processes of (a) to (f).					
c) Private area for patient counseling session					
Facility Comments:					
18.4.1.5	Security requirements for the Pharmacy Services shall address both facilities and staff protection including proper access controls and equipment. a) the design and operational policy shall facilitate controlled access and secure locking up of the facility to ensure the security of goods and staff at all times; b) the design and operation shall include equipment and features like duress alarms.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	EVIDENCE OF COMPLIANCE	1. Design and operational policy for controlled access and security of the pharmacy facilities.						
		2. Physical layout inspection of the pharmacy conforms to security and access control requirements.						
	Facility Comments:							
18.4.1.6	The equipment used for measuring and monitoring shall be checked and calibrated at suitable predetermined intervals and the results of such checks shall be recorded and retained. i) measuring or monitoring equipment need to be calibrated; ii) alarms or alerts need to be remotely connected.							
	EVIDENCE OF COMPLIANCE	1. Records on planned preventive maintenance (PPM), corrective maintenance and calibration on equipment used for measuring and monitoring.						
		2. Alarm tests and records						
	Facility Comments:							
18.4.1.7 CORE	There is evidence that the facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.							
	EVIDENCE OF COMPLIANCE	1. Planned Preventive and Predictive Maintenance records such as schedule, stickers, etc.						
		2. Planned Replacement Programme where applicable						
		3. Complaint records						
		4. Asset inventory						
	Facility Comments:							
18.4.1.8	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.							

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	EVIDENCE OF COMPLIANCE	1. Testing, commissioning and calibration records (certificates or stickers)						
		2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as evidence of compliance to the relevant standards and Acts.						
	Facility Comments:							
18.4.1.9	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment. Notes/Explanations Examples of specialised equipment are laminar flow cabinets, isolators, etc.							
EVIDENCE OF COMPLIANCE	1. User training records							
	2. Competency assessment record							
	3. Letter of authorisation							
	4. List of staff trained and authorised to operate specialised equipment							
Facility Comments:								

SURVEY ITEM &SELF-ASSESSMENT					
TOPIC 18.5:		<u>SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES</u>			
STANDARD <u>18.5.1</u>		<i>The Head of Pharmacy Services shall ensure the provision of quality performance and safety of patients with staff involvement in the continuous safety and performance improvement activities of the Pharmacy Services.</i>			

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
18.5.1.3	The Head of Pharmacy Services shall ensure that the staff are trained in risk management and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility.				
	Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.				
	EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:			
		a) Training of staff			
		b) Policy on incident reporting			
		d) Methodology of incident reporting			
		f) Register/records of incidents			
		2. Completed incident reports			
		3. Root Cause Analysis			
		4. Corrective and preventive action plans			
		5. Remedial measures			
	6. Minutes of meetings				
	7. Acknowledgment by Head of Service and PIC/Hospital Director				
	8. Feedback given to staff regarding incident reporting.				
Facility Comments:					
18.5.1.4 CORE	There is tracking and trending of specific performance indicators not limited to but at least two (2) of the following:				
	a) percentage of prescription error				
	b) percentage of dispensing error				
	c) average time for a prescription to be dispensed from time received at counter to time medication given to patient				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	d) number and value of expired drugs at end of month over a specified period							
	EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored.						
		2. Records on tracking and trending analysis.						
		3. Remedial measures taken where appropriate						
	Facility Comments:							
18.5.1.5	Feedback on results of safety and performance improvement activities are regularly communicated to the staff and relevant authority.							
	EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff.						
		2. Evidence of feedback via communication on results of performance improvement activities through continuing education activities/meetings.						
		3. Minutes of service/unit/committee meetings						
	Facility Comments:							
18.5.1.6	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.							
	EVIDENCE OF COMPLIANCE	1. Documentations on performance improvement activities and performance indicators.						
		2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						
	Facility Comments:							

SERVICE SUMMARY	
SURVEYOR SUMMARY:	
OVERALL RATING:	
OVERALL RISK:	

SURVEY ITEM & SELF-ASSESSMENT

SERVICE STANDARD 19 : CENTRAL STERILISING SUPPLY SERVICES (CSSS)

PREAMBLE

The Central Sterilising Supply Services (CSSS) provide sterilising services for all areas within the Facility. It shall comprise of all activities relating to disinfection and sterilisation processes in the Facility. The services shall be located to:

- a) avoid contamination of clean and sterile supplies and equipment;*
- b) prevent heat and noise to patient care areas;*
- c) eliminate thoroughfare traffic;*
- d) facilitate delivery and return of supplies and equipment to and from other services and/or external facility.*

The scope of services at the Central shall include:

- a) To receive, decontaminate (disassembling, washing, cleaning, disinfection and dry), packaging (inspection, functionality check and packing) and sterilization of reusable medical devices to a level that provides an assurance of sterility.*
- b) Disinfection and sterilization for Robotic Instruments.*
- c) Disinfection and sterilization of Rigid Endoscopic instruments*
- d) Preparation and Sterilization of soft goods before distribution to healthcare facilities.*
- e) Preparation and sterilization of reusable surgical textiles (dressing towels, operation gown, draped)*
- f) Sterile storage and distribution*

Facilities that do not have their own CSSS or cannot provide a full range of services, shall arrange with an external facility to provide the services needed. The services provided by the external facility shall comply with the relevant MSQH Standards of Accreditation.

TOPIC 19.1: ORGANISATION AND MANAGEMENT**STANDARD**
19.1.1

The Central Sterilising Supply Services (CSSS) is organised and administered to provide optimum support and service to patient care providers according to the goals and objectives of the Facility. The Head of CSSS shall be a healthcare professional with relevant professional certification and experience in infection control and management of supply and processing of CSSS.

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
19.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Central Sterilising Supply Services are clearly documented and measurable. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.				
		2. Goals and objectives of the Central Sterilising Supply Services in line with the Facility statements are available, endorsed and dated.				
		3. Evidence of planned reviews of the above statements.				
		4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)				
		5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.				
	Facility Comments:					
19.1.1.2 CORE	There is an organisation chart which: a) provides a clear representation of the structure, functions and reporting relationships between the Head and staff of Central Sterilising Supply Services; b) is accessible to all staff and clients; c) includes off-site services if applicable; d) is revised when there is a major change in any of the following: i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns.					
	EVIDENCE OF COMPLIANCE	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Head and staff of Central Sterilising Supply Services.				
		2. Organisation chart of the service is endorsed, dated and accessible.				

		3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).				
		Facility Comments:				
19.1.1.3		Where sterilisation services are provided in areas other than the main CSSS, for example operating theatre (OT), Dental Services, responsibility for the operation of these services is the Head of the CSSS and is clearly defined. Appropriate instructions and supervision of staff equipment maintenance and quality control are carried out and documented.				
	EVIDENCE OF COMPLIANCE	1. Letter of authorisation from the Person In Charge (PIC) that all sterilisation activities within the Facility which includes Dental, Endoscopy, operating suite services, etc to be monitored by the Head of CSSS.				
		2. Documentation on regular monitoring of the sterilisation services outside the CSSS within the Facility to ensure effectiveness of the disinfection and sterilising process including validation.				
		Facility Comments:				
19.1.1.4		Regular staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Central Sterilising Supply Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.				
	EVIDENCE OF COMPLIANCE	1. Minutes are accessible, disseminated and acknowledged by the staff.				
		2. Attendance list of members with adequate representatives of the service.				
		3. Frequency of meetings as scheduled.				
		4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).				
		Facility Comments:				
19.1.1.5		The Head of Central Sterilising Supply Services is involved in the planning, justification and management of the budget and resource utilisation of the services.				

	EVIDENCE OF COMPLIANCE	1. Minutes of Facility-wide management meeting – indicates Head of CSSS is involved in the planning, management and justification of the budget and resource utilisation of CSSS facilities and services.				
		2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service.				
		3. Approved budget and resources				
	Facility Comments:					
19.1.1.6	The Head of the CSSS is involved in the appointment and/OR assignment of the staff.					
	EVIDENCE OF COMPLIANCE	1. Records on staff interview (if applicable)				
		2. Appointment/assignment letter of Head of Service				
		3. Job description of Head of Service				
		4. Records on staff deployment				
		5. Duty roster				
	Facility Comments:					
19.1.1.7	Appropriate statistics and records shall be maintained in relation to the provision of CSSS and used for managing the services and patient care purposes.					
	EVIDENCE OF COMPLIANCE	1. Records are available but not limited to the following:				
		a) workload/census;				
		b) annual report;				
		c) accident/incident reports;				
		d) staffing number and staff profile;				
		e) staff training records;				
		f) data on performance improvement activities, including performance indicators.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT

**Standard
19.1.2**

Facilities that do not have their own CSSS or cannot provide a full range of services, shall arrange with an external facility to provide the services needed. The services provided by the external facility shall comply with the relevant MSQH Standards of Accreditation.

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
19.1.2.1	The services are approved by the Person In Charge (PIC) of the Facility.				
	EVIDENCE OF COMPLIANCE	1. Evident of a valid agreement between external service provider and the Facility describing the Terms of Agreement including adequate number of appropriately qualified personnel on-site as approved by PIC of the Facility.			
	Facility Comments:				
19.1.2.2	The external providers of the CSSS shall comply with all relevant MSQH Standards of Accreditation.				
	EVIDENCE OF COMPLIANCE	1. External providers of CSSS comply with the requirements of MSQH Standards for the service.			
	Facility Comments:				
19.1.2.3 CORE	Where CSSS are provided by an external source, there is a written agreement between the external service provider and the Facility stating the requirements for the services that include the following:				
	a) formal lines of communication and responsibilities between the external service provider and the Facility; b) provision of adequate numbers of appropriately qualified personnel to perform their duties;				

	c) participation, as appropriate, of the external service provider in committees of the Facility; d) arrangement for adequate pickup and delivery; e) arrangements for after-hours and emergency services; f) mechanisms for dealing with problems in service delivery; g) adequate facilities and equipment for providing the services at the Facility and at the site of the external services for decontamination, sterilisation, packaging, storage and issuance of supplies; h) involvement of the external service provider in safety and performance improvement activities of the Facility, as appropriate; i) comply with the appropriate MSQH Standards of Accreditation for CSSS which functions within the Facility.				
	EVIDENCE OF COMPLIANCE	1. Agreement between external service provider and the Facility address the requirements for the service but not limited to items (a) to (i).			
		2. Reports on verification (visits) on the provision of CSSS services provided by the external source based on:			
		a) established policies and procedures;			
		b) records and analysis report related to safety and performance improvement activities;			
		c) regular audits of the site to verify the services involving decontamination, sterilisation, packaging, storage and issuance of supplies;			
		d) evidence of related audit reports;			
		e) evidence of valid autoclave licence by the Department of Occupational Safety and Health and operated by trained autoclave operator(s).			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT	
TOPIC 19.2	<u>HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT</u>
STANDARD 19.2.1	<i>The CSSS is managed by a healthcare professional with the relevant professional certification and experience in infection control and in the management of supply and processing of CSSS and is adequately staffed to achieve the goals and objectives of the CSSS.</i>

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
19.2.1.1 CORE	The Head of CSSS shall be a healthcare professional with training and experience and shall be responsible to coordinate all (on-site or off-site) disinfection and sterilisation processes in the Facility.			
	1. Duties and responsibilities for disinfection and sterilisation processes are:			
	a) prescribed in the job description of Head of CSSS;			
	b) described in the services' policy.			
	Facility Comments:			
19.2.1.2	The Head and staff of the CSSS shall be individuals qualified by education, training, experience and certification to commensurate with the requirements of the various positions.			
	1. Records on credentials of Head of Service and staff required to fill up the posts within the service (to match the complexity of the Facility and services) and registration.			
	2. Minimum post basic trained in perioperative care with CSSS module for Head of Service			
	3. Appointment letters			
	4. Certification where required, i.e. autoclave operator			
	5. Training and competency records including training in infection control and privileging for specific job scope.			
	Facility Comments:			

19.2.1.3	The authority, responsibilities and accountabilities of the Head of CSSS are clearly delineated and documented.					
	EVIDENCE OF COMPLIANCE	1. Appointment letter for Head of Service.				
		2. Description of duties and responsibilities.				
	Facility Comments:					
19.2.1.4	Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the need of the services.					
	EVIDENCE OF COMPLIANCE	1. Number of staff and qualification should commensurate with workload.				
		2. Staffing pattern				
		3. Duty roster				
		4. Workload census and statistics				
	Facility Comments:					
19.2.1.5	There are written and dated specific job descriptions for all categories of staff that include: a) qualifications, training, experience and certification required for the position; b) lines of authority; c) accountabilities, functions and responsibilities, d) reviewed when required and when there is a major change in any of the following: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations.					
	EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (d).				
		2. Job description includes specialisation skills				
		3. Relevant privileges granted where applicable/authorisation to operate specialised equipment , e.g. autoclave.				
		4. The job description is acknowledged by the staff and signed by the Head of Service/Unit and dated.				

	Facility Comments:				
19.2.1.6	Personnel records on training, staff development, leave and others are maintained for every staff. Note: Staff personal record may be kept in Human Resource Department as per Facility policy.				
	EVIDENCE OF COMPLIANCE	1. Staff personal records include:			
		a) staff biodata;			
		b) qualification and experience;			
		c) training record;			
		d) competency record and privileging/authorisation to operate specialised equipment, e.g. autoclave;			
		e) leave record;			
		f) confidentiality agreement.			
		g) immunisation records			
	Facility Comments:				
19.2.1.7 CORE	Provision of vaccination programmes for all staff exposed to sharps injury and biological hazards.				
	EVIDENCE OF COMPLIANCE	1. Vaccination programme			
		2. Vaccination records			
	Facility Comments:				
19.2.1.8	There is a structured orientation programme where new staff are briefed on their services, operational policies and relevant aspects of the Facility to prepare them for their roles and responsibilities.				
	EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme.			
		2. Records on structured orientation programme			
		3. Orientation Brief			
		4. List of attendance			
	Facility Comments:				

19.2.1.9	There is evidence of training needs assessment and staff development plan which provides the knowledge and skills required for staff to maintain competency in their current positions and future advancement.					
	EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and gaps identified.				
		2. A staff development plan based on training needs assessment is available.				
		3. Training schedule/calendar is in place.				
		4. Training module				
	Facility Comments:					
19.2.1.10	There are continuing education activities for staff to pursue professional interests and to prepare for current and future changes in practice.					
	EVIDENCE OF COMPLIANCE	1. Continuing education activities and schedule				
		2. Contents of training programme				
		3. Training records on continuing education activities are kept and maintained for each staff.				
		4. Certificate of attendance/degree/post basic training.				
	Facility Comments:					
19.2.1.11	Staff receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.					
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff is completed upon probationary period and as an annual exercise.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT	
TOPIC 19.3:	<u>POLICIES AND PROCEDURES</u>
STANDARD 19.3.1	<i>There are documented policies and procedures that reflect current principles of disinfection and sterilising practices and processes of CSSS. These policies and procedures shall be consistent with relevant regulations, statutory requirements and goals and objectives of the CSSS.</i>

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
19.3.1.1 CORE	There are written policies and procedures for the CSSS which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated.				
	There is a mechanism for and evidence of a periodic review at least once in every three years.				
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for the service.			
		2. Policies and procedures are consistent with regulatory requirements and current standard practices.			
		3. Evidence of periodic review of policies and procedures.			
		4. The policies and procedures are endorsed and dated.			
	Facility Comments:				
19.3.1.2	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved.				
Cross departmental collaboration is practised in developing relevant policies and procedures where applicable, e.g. infection control in Central Sterilising Supply Services.					

	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.				
		2. Minutes of meeting with evidence of cross reference with other departments.				
		3. Documented cross departmental policies				
	Facility Comments:					
19.3.1.3	Current policies and procedures are communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings				
		2. Circulation list and acknowledgement				
	Facility Comments:					
19.3.1.4 CORE	There is evidence of compliance with policies and procedures.					
	EVIDENCE OF COMPLIANCE	1. Compliance with policies and procedures through:				
		a) interview of staff on practices;				
		b) verify with observation on practices;				
		c) results of audit on practices;				
		d) practices in line with established policies and procedures.				
	Facility Comments:					
19.3.1.5 CORE	Policies and procedures of the CSSS shall include the following:					
	a) receiving and decontamination processes (disassembling, washing, cleaning and disinfection); b) packaging process (inspection, functionality check and packing); c) sterilisation process; d) validation processes; e) sterile storage and distribution; f) traceability and product recall; g) services provided to other healthcare facilities; h) environmental control (storage condition, effective maintenance of sterility);					

	i) Management of sterile items (event related or shelf life) j) safety practices in CSSS; k) utilisation of “flash” autoclave l) Management of Loaner Instrumentation (refer to Guideline On Loaner Instrumentation book MSSA, ANSI/AAMI ST79:2017 Page 30 5.2.3 Loaned or borrowed instrumentation.) m) Management of Robotic Instrumentation n) Management implantable items (MSSA : Malaysian Standard Of Sterilization Process Book 3 rd Edition 2018 Page 121) cross reference with infection control standard				
	EVIDENCE OF COMPLIANCE	1. Policies and procedures that address CSSS processes but not limited to items (a) to (k) are available.			
	Facility Comments:				
19.3.1.6	Disinfection and sterilising processes in other services, e.g. Dental Services, Theatre Sterile Supply Unit (TSSU), Endoscopy, Cardiovascular Invasive Laboratory, Fertility Centre etc should be consistent with the requirements of policies and procedures of the CSSS.				
EVIDENCE OF COMPLIANCE	1. Specific policies and procedures and/or practice guidelines which address disinfection and sterilising processes that meet the requirements of CSSS are available in other services, i.e. Dental Services, TSSU, Endoscopy, Cardiovascular Invasive Laboratory, Fertility Centre etc				
Facility Comments:					
19.3.1.7	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.				

	EVIDENCE OF COMPLIANCE	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference:					
		a) Equipment operating manuals					
		b) Factory and Machinery Act					
		c) Medical device operating manuals					
		d) Occupational Safety and Health Act					
		e) Infection Control Manual					
		f) Malaysian Standard of Sterilization Process (MSSA document)					
	Facility Comments:						
19.3.1.8	There shall be no reprocessing of any single-use medical-surgical instruments, equipment or supplies.						
	EVIDENCE OF COMPLIANCE	1. Policy on 'No reprocessing' of any single-use medical-surgical instruments, equipment or supplies.					
		2. Compliance with 'No reprocessing' policy.					
	Facility Comments:						
19.3.1.9	Records for all activities in the processing of sterile items shall be maintained for a period of time as defined by respective regulatory authorities or in their absence as per policy of the healthcare facility.						
	EVIDENCE OF COMPLIANCE	1. Daily production statistics to assess stock (e.g. medical-surgical instruments, equipment or supplies) levels for safe, continuous service, efficient stock and cost control.					
		2. All tests performed on equipment and results.					
		3. Steriliser records, e.g. number of cycles					
	Facility Comments:						

SURVEY ITEM & SELF-ASSESSMENT	
TOPIC 19.4:	<u>FACILITIES AND EQUIPMENT</u>
STANDARD 19.4.1	<i>There are adequate facilities and equipment to enable the CSSS to meet its goals and objectives in accordance with regulatory requirements.</i>

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
19.4.1.1 CORE	The design and set up of the Central Sterilising Supply Services allows for: a) The CSSS to be equipped and arranged to provide proper separation of clean and dirty routes and processes with clear demarcation of the different zones. The airflow is from clean to soiled areas. b) Areas within CSSS shall be adequate to provide for: i) <u>Receiving of unsterile supplies</u> ● Handling of supplies and equipment in accordance with planned stores and supply system and parking of carts. ● Facilities for receiving, disassembling and cleaning of supplies and equipment shall be appropriately located avoiding non-sterile items passing through sterile areas of the CSSS. ii) <u>Assembling and Packaging</u> ● Facilities for assembling, packaging supplies and equipment shall have hand hygiene facilities, work counter (a non-porous material work benches) or its equivalent as required by types and volume of items. iii) <u>Sterilising</u> ● Facilities for sterilising shall be located between packaging area and sterile storage area. ● An exhaust is installed over the back room of sterilisers to prevent condensation and heat building up.			

	● A designated cooling area with good ventilation to allow cooling of sterilised items. iv) <u>Storage Facilities</u> ● Dedicated store for storage and issue of sterile instruments and supplies ● Facilities for storage and issues of unsterilised linen for sterilization. ● Facilities for storage and issue of unsterile instruments, ● Facilities for storage and issue of chemical detergents and disinfectants ● Facilities for storage of soft goods ● Facilities for storage (sterilization wrapping paper, autoclave tape etc) c) Hand washing facilities d) Staff changing room are readily available. e) Suitably planned layout of work benches and equipment.					
	EVIDENCE OF COMPLIANCE	1. The design and set up of the CSSS address all items (a) to (e) as per relevant regulations and as evidenced by:				
		a) demarcation with physical structure where control of airflow is from positive to negative pressure;				
		b) facilities for reception process; there should be no crises crossing of non-sterile and sterile items;				
		c) appropriate areas/zones that facilitates the activities of CSSS;				
		d) compliance with Infection Control Policies;				
		e) absence of porous work benches at assembling and packaging area.				
	Facility Comments:					
	19.4.1.2	There are adequate and appropriate facilities and equipment with proper utilisation of space to enable staff to carry out their professional and administrative functions.				
EVIDENCE OF COMPLIANCE		1. Adequate and proper utilisation of space.				
		2. Appropriate equipment to match the complexity of services.				
		3. Easy access and clear exit routes				
Facility Comments:						

19.4.1.3	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.					
	EVIDENCE OF COMPLIANCE	1. Testing, commissioning, and calibration records (certificates or stickers)				
		2. Certification of equipment from certified bodies, e.g. Department of Occupational Safety and Health (DOSH), Standards and Industrial Research Institute of Malaysia (SIRIM), etc as evidence of compliance to the relevant standards and Acts.				
	Facility Comments:					
19.4.1.4	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment, e.g. autoclave.					
	EVIDENCE OF COMPLIANCE	1. User training records				
		2. Competency assessment record				
		3. Letter of authorisation				
		4. List of staff trained and authorised to operate specialised equipment				
	Facility Comments:					
19.4.1.5 CORE	There is evidence that the Facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.					
	EVIDENCE OF COMPLIANCE	1. Planned Preventive Maintenance records such as schedule, stickers, etc.				
		2. Planned Replacement Programme where applicable				
		3. Certificate of Fitness of Autoclave/pressure vessels from Department of Occupational Safety and Health (DOSH)				
		4. Complaint records				
		5. Asset inventory				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT	
TOPIC 19.5:	<u>SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES</u>
STANDARD 19.5.1	<i>The Head of CSSS shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of CSSS in risk mitigation.</i>

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
19.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the CSSS. The process includes: a) Planned activities i.e. risk identification using the risk rating matric and develop risk register b) Data collection and verification c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.				
	EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to (f).			
		2. Records on performance improvement activities. / studies			
		3. Minutes of performance improvement meetings			
		4. CSSS risk register			
		5. Evidence of risk register being reviewed			
		6. Records on innovation if available			
	Facility Comments:				
19.5.1.2	The Head of CSSS has assigned the responsibilities for planning, monitoring and managing safety and performance improvement to appropriate individual/personnel within the respective services.				

	EVIDENCE OF COMPLIANCE	1. Collection, tabulation and verification of data								
		2. Discussed with relevant department								
		3. Identify areas for improvement								
		4. Endorsement of outcome to Head of Nursing and PIC								
Facility Comments:										
19.5.1.3	The Head of the CSSS shall ensure that the staff are trained in incident reporting. Incident reports are reported timely, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility.									
	Incidents reported have Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.									
	EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:								
		a) Training of staff								
		b) Policy on incident reporting								
		c) Methodology of incident reporting								
		d) Register/records of incidents								
		2. Timely complete incident reports								
		3. Root Cause Analysis								
		4. Corrective and preventive action plans								
		5. Remedial measures implemented and monitored								
		6. Minutes of meetings								
		7. Acknowledgment by Head of Service and PIC/Hospital Director								
		8. Outcome of lesson learnt from the incident shared with other Feedback given to staff regarding incident reporting.								
	Facility Comments:									

19.5.1.4 CORE	There is evidence of tracking and trending of specific performance indicators for improvement of the services /patient care such as : a) percentage of sterile instrument sets rejected (Target: Not more than 5%) b) percentage of incidents reported monthly that have had Root Cause Analysis (RCA) done and action taken to prevent recurrence c) Internal Customer feed back d) Leak testing for rigid container system to ensure sterility							
	EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored.						
		2. Records on tracking and trending analysis.						
		3. Remedial measures taken where appropriate						
		4. Review performance indicators if trending shows consistent achievement over 1 year. Identify new performance indicators						
Facility Comments:								
19.5.1.5	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.							
	EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff.						
		2. Evidence of feedback via communication on results of performance improvement activities through continuing education activities/meetings.						
		3. Minutes of service/unit meetings						
	Facility Comments:							
19.5.1.6	Appropriate documentation of safety and performance improvement activities are kept, and confidentiality of medical practitioners, staff and patients is preserved.							
	EVIDENCE OF COMPLIANCE	1. Documentation on performance improvement activities and performance indicators.						
		2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						
	Facility Comments:							

SURVEY ITEM & SELF-ASSESSMENT

TOPIC 19.6: **SPECIAL REQUIREMENTS****STANDARD**
19.6.1*The CSSS shall be responsible to provide centralised sterilising services and sterile supplies for all areas within the Facility that use sterile instruments, dressings, linen and other items.*

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
19.6.1.1 CORE	There is a properly set up centralised sterile supply system designed to reduce the risk of infection to both patients and staff. This system shall be an integral part of the Facility's infection control programme that address: a) structural layout of CSSS with clear delineation between sterile and non-sterile areas to prevent cross contamination; b) building finishes; c) mechanical and electrical installation including fire safety system; d) appropriate equipment and fixtures; e) environmental control; f) staff traffic flow.				
	EVIDENCE OF COMPLIANCE	1. <u>Structural layout</u>			
		a) Physically demarcated zones for decontamination, packaging, sterilising, sterile store and distribution counter.			
		b)			
		c) Good ventilation system with temperature and humidity control as per standard requirements.			
		d) Infection control aspects – appropriate personal protective equipment, staff changing room and hand washing facilities.			
	e) Workplace safety – staff safety, noise control, waste management.				

		f) Fire safety fixtures, e.g. fire suppression system.				
		2. Building finishes cross references with standard 3 (Transfer to engineering)				
		a) Floors and walls should be constructed of materials that will withstand periodic wet vacuuming or washing. These materials should not be of a particulate- or fibre-shedding composition.				
		b) The finish, the screed and sub-floor must be suitable for heavy trolley traffic. The flooring should be turned up at wall in an integral cover skirting which should be continuous with floor and be finished flush with the wall. The finish must be hardwearing and easy to clean.				
		c) Work areas ceilings should be constructed to create a flush surface with recessed, enclosed fixtures.				
		d) For new CSSS facilities, the pipes and sewerage line should be routed away from the structure design of ceilings, walls and floors of the operation areas of the facilities.				
		e) For the existing CSSS facilities, the pipes and sewerage line running above the ceiling, walls and floors, periodic risk assessment and control measures to be instituted and documented.				
		f) Artificial lighting – Good artificial lighting is required, supplementing natural light when appropriate. Switching should permit control in different work areas of large rooms. The lighting is required where instruments and other items are inspected and should preferable be adjustable to suit the operative and the task being undertaken.				
		g) The ventilation system should be designed so that air flows into relatively soiled areas from clean adjoining spaces (via negative pressure), and is exhausted to the outside or to a filtered partial recirculation system. The air circulation should be of a down draft-type. Fans should not be permitted in any area of central service.				

		h) Washer disinfectors and steriliser emit considerable heat and humidity. Electronic controls essential for the correct operating of equipment can be affected. Working condition can become intolerable unless fully insulated machine are selected, all pipe work is insulated and extract ventilation is provided specific to these machines.				
		3. <u>Mechanical and electrical installation:</u>				
		a) Certificates from relevant authorities i.e. Department of Occupational Safety and Health (DOSH) for autoclaves				
		b) Planned Preventive Maintenance (PPM) and repair records				
		c) Competent staff for mechanical and electrical installation as per regulatory requirements.				
		d) Validation of installations (e.g. Testing and Commissioning records).				
		4. <u>Appropriate equipment and fixtures:</u>				
		a) automated equipment and fixtures as per 19.6.1.6;				
		b) Non automated equipment and fixtures:				
		i) manual cleaning – appropriate cleaning tools, three-compartments sinks				
		ii) spray gun;				
		iii) dryer;				
		iv) magnify glass.				
		c) transportation trolley;				
		d) Sterilizer				
		5. <u>Environmental control</u>				
		a) All work areas shall maintain temperature between 20°C ±2 - 24°C				
		b) Temperature for sterile storage as per criterion 19.6.1.5 and humidity 50%-60%.				
		6. <u>Fire safety system:</u>				
		a) Fire safety system shall meet fire authority's requirements.				
		b) Appropriate fire suppression system according with the natural of fire agents.				
		c) Fire evacuation plan is easily visible at the respective zones.				

		d) Fire safety requirements:					
		i). fire safety training and records;					
		ii). appropriate firefighting systems are available;					
		iii). fire safety audit;					
		iv). evacuation plan;					
		v). evacuation route;					
		vi). fire drill and report.					
		7. <u>Staff traffic flow</u>					
		a) For internal staff, there is designated route with sign posting between the demarcated zones.					
		b) For external client, entrance and exit to the CSSS facility is restricted and compliance with dress code.					
Facility Comments:							
19.6.1.2	All sterilising systems (e.g. hot air, steam, gas) are maintained in accordance with statutory regulations.						
	EVIDENCE OF COMPLIANCE	1. Valid licence for steam sterilisers and other type of sterilisers.					
		2. Log book of CSSS installation of vessels and chambers.					
	Facility Comments:						
19.6.1.3	Clean linen to be sterilised shall be inspected and folded in a room set aside for this purpose, which shall be separate from the main sterilising area. An exhaust system shall be installed to remove cotton fluff and ensure staff safety.						
	EVIDENCE OF COMPLIANCE	1. Separate room for linen inspection and preparation					
		2. Illuminated linen inspection table					
		3. Exhaust system/Lint extractor					
	Facility Comments:						
19.6.1.4	Arrangements are made for supplies required after normal office hours.						

	EVIDENCE OF COMPLIANCE	1. Policy on accessibility of Central Sterilising Supply Services for 24 hours.				
		2. On call roster of assigned staff to attend to CSSS.				
		3. Mechanism to retrieve sterilised instruments from sources where not required.				
	Facility Comments:					
19.6.1.5 CORE	In the sterile store, there is environmental control on ventilation (100% fresh air intake with positive pressure), temperature (20°C ± 2) and humidity (55% ± 5) and the system is regularly inspected and maintained. Air discharge exhaust shall be located to avoid cross circulation to air supply intakes.					
	EVIDENCE OF COMPLIANCE	1. Appropriate temperature and humidity measurement devices				
		2. Record of humidity and temperature readings				
		3. Records on corrective actions where there are deviations to the readings above.				
	Facility Comments:					
19.6.1.6 CORE	There are special automated equipment appropriate to the CSSS for the cleaning, drying, and sterilisation of medical equipment and instruments, and they comply with acceptable standards.					
	EVIDENCE OF COMPLIANCE	1. Appropriate equipment to match complexity of the facility's services such as:				
		a) washer disinfectant - Dosage of detergent - Dosage of lubricant (if available) - Quality of water - Carried out Test object Surgical Instrument (TOSI)				
		b) Ultrasonic machine - To check efficacy of ultrasonic wave - SonoCheck (Dosimeter) Test				
		c) Dryer Temperature monitoring				

		d) Heat sealing machine Seal check				
		e) Sterilizer - quality of water (the best water to use is distilled water or demineralized water or water prepared by process known as reverse osmosis). - quality of steam				
		f) rapid biological test incubator;				
		g) endoscope washer (cross reference to PCI and endoscopic standard)				
		h) Laparoscopic Insulation Tester.				
		Facility Comments:				
19.6.1.7 CORE		Validation tests on sterilisation process using mechanical, chemical and biological tests are conducted and results monitored and recorded accordingly.				
	EVIDENCE OF COMPLIANCE	1. Performance of relevant tests and results:				
		a) mechanical test results records;				
		b) chemical test result records;				
		c) biological test result records.				
		2. Records on deviations if any and corrective and preventive actions taken				
		3. Relevant efficacy test records considering mechanical aspects, chemical aspects, temperature and time.				
		Facility Comments:				
19.6.1.8		The CSSS Unit shall make appropriate arrangement for the collection of dirty instruments and the distribution of sterilised surgical instruments/surgical supplies from the CSSS Unit to the various services areas of the Facility which include but not limited to: a) policy on distribution of sterilised surgical instruments and supplies; b) planned schedule and timing; c) dedicated and cleaned vehicle for distribution; d) cleaned transport trolley.				

	EVIDENCE OF COMPLIANCE	1. On-site inspection on compliance with (a) to (d).				
	Facility Comments:					
19.6.1.9	<u>Waste management</u> a) Waste disposal shall be in accordance with national and local regulations. Waste generated by the sterilising processing unit shall be placed in appropriate containers/bags. b) All contaminated waste such as: i) soiled surgical dressings , e.g. cottonwool, gloves, swabs; ii) human biopsy materials, human tissue, blood, urine, stools. shall be discarded into appropriate containers and disposed in accordance with the Facility's policy. c) Used vials of biological indicators for monitoring of sterilisation shall be disposed in accordance with the Facility's policy. d) Sharp containers shall be provided for disposal of condemned needles, used single needles and syringes, blades and other sharp items inadvertently returned to the sterilising processing facility with reusable items. The collection container must be puncture resistant and leak tight. This category of waste has to be disposed/destroyed completely as to prevent potential risk of injury/infection. e) All waste should be removed from the sterilising processing facility via a designated disposal exit.					
	EVIDENCE OF COMPLIANCE	1. Policy on segregation and collection of waste.				
		2. Planned schedule by facilities.				
		3. Dedicated route.				
		4. Record of waste collection.				
	Facility Comments:					

SERVICE SUMMARY**SURVEYOR SUMMARY:****OVERALL RATING:****OVERALL RISK:**

SURVEY ITEM & SELF-ASSESSMENT				
SERVICE STANDARD 20 : HOUSEKEEPING SERVICES				
	<u>PREAMBLE</u> <i>The Housekeeping Services may be provided from within the Facility by either own staff or contract staff. The services may also be contracted to a qualified external contractor. In this situation, the standards and criteria mentioned below and those standards for Prevention and Control of Infection are also applicable.</i>			
<u>TOPIC 20.1:</u> <u>STANDARD 20.1.1</u>	<u>ORGANISATION AND MANAGEMENT</u> <i>The Housekeeping Services are organised and administered to provide a pleasant, safe and sanitary environment in support of the optimum care for patients according to the goals and objectives of the Healthcare Facility.</i>			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT SURVEYOR RATING
20.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Housekeeping Services are clearly documented and measurable. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.			
	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.		
		2. Goals and objectives of the Housekeeping Services in line with the Facility statements are available, endorsed and dated.		
		3. Evidence of planned reviews of the above statements.		
		4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)		

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.					
	Facility Comments:					
20.1.1.2 CORE	There is an organisation chart which: a) provides a clear representation of the structure, function and reporting relationships between the Head and staff of Housekeeping Services; b) is accessible to all staff and clients; c) includes off-site services if applicable; d) is revised when there is a major change in any of the following: i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns.					
	EVIDENCE OF COMPLIANCE	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Head and staff of Housekeeping Services.				
		2. Organisation chart of the service is endorsed, dated and accessible.				
		3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).				
	Facility Comments:					
20.1.1.3	Regular staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Housekeeping Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.					
	EVIDENCE OF COMPLIANCE	1. Minutes are accessible, disseminated and acknowledged by the staff.				
		2. Attendance list of members with adequate representatives of the service.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		3. Frequency of meetings as scheduled.				
		4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).				
	Facility Comments:					
20.1.1.4	The Head of Housekeeping Services is involved in the planning, justification and management of the budget and resource utilisation of the services.					
	EVIDENCE OF COMPLIANCE	1. Minutes of Facility-wide management meeting				
		2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service.				
		3. Approved budget and resources.				
	Facility Comments:					
20.1.1.5	The Head of Housekeeping Services is involved in the appointment and/OR assignment of staff.					
	EVIDENCE OF COMPLIANCE	1. Records on staff interview (if applicable)				
		2. Appointment/assignment letter of Head of Service				
		3. Job description of Head of Service				
		4. Records on staff deployment				
		5. Duty roster				
	Facility Comments:					
20.1.1.6	Appropriate statistics and records shall be maintained in relation to the provision of Housekeeping Services and used for managing the services and patient care purposes.					
	EVIDENCE OF COMPLIANCE	1. Records are available but not limited to the following:				
		a) workload/census;				
		b) annual report;				
		c) accident/incident reports;				
		d) staffing number and staff profile;				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		e) staff training records;				
		f) data on performance improvement activities, including performance indicators;				
		g) customer feedback;				
		h) audit inspection records.				
	Facility Comments:					
20.1.1.7 CORE	Where services are provided by an external source, there is a written agreement between the external service provider and the Facility stating the requirements for service delivery, including the following: a) formal lines of communication and responsibilities between the external service provider and the Facility; b) provision of adequate numbers of appropriately qualified personnel to perform their duties; c) participation, as appropriate, of the external service provider in committees of the Facility i.e. Prevention and Control of Infection; d) arrangement for adequate pick-up and delivery; e) arrangements for after-hours and emergency services; f) mechanisms for dealing with problems in service delivery; g) adequate facilities and equipment for providing the services at the Facility and at the site of the external service; h) involvement of the external service provider in safety and performance improvement activities of the Facility, as appropriate; i) comply with the appropriate MSQH Standards of Accreditation for Housekeeping Services which function within the Facility.					
EVIDENCE OF COMPLIANCE	1. Written agreement which include items (a) to (i) between the external service provider and the Facility is endorsed, signed and dated.					
	2. Written agreement between the external service provider and its sub-contractors is signed and dated. The agreement is endorsed and consented by the Facility.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		3. Evaluation of vendor for appointment				
	Facility Comments:					
20.1.1.8 CORE	Where services are provided by an external source, the Person In Charge (PIC) of the Facility shall appoint a person to supervise, monitor and provide technical input to the housekeeping services.					
	EVIDENCE OF COMPLIANCE	1. Appointment letter of liaison officer with terms of reference.				
		2. Job description				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT								
<u>TOPIC 20.2</u>		<u>HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT</u>						
<u>STANDARD 20.2.1</u>		<i>The Housekeeping Services shall be directed and adequately staffed with appropriately qualified and trained personnel to achieve the goals and objectives of the services.</i>						
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
20.2.1.1	The Head and staff of the Housekeeping Services shall be individuals qualified by education, training, and experience to commensurate with the requirements of the various positions.							
	EVIDENCE OF COMPLIANCE	1. Records on qualification and experience of Head of Service and staff related to housekeeping services						
		2. Appointment/assignment letters						
		3. Training and competency records						
	Facility Comments:							
20.2.1.2	The authority, responsibilities and accountabilities of the Head of Housekeeping Services are clearly delineated and documented.							
	EVIDENCE OF COMPLIANCE	1. Appointment/assignment letter for Head of Service.						
		2. Description of duties and responsibilities.						
	Facility Comments:							
20.2.1.3 CORE	Sufficient numbers of personnel and support staff with appropriate qualifications and experience are employed to meet the need of the services.							
	EVIDENCE OF COMPLIANCE	1. Number of staff and qualification and experience commensurate with workload.						
		2. Staffing pattern						
		3. Duty roster						
		4. Census on workload						

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS										
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING									
	Facility Comments:												
20.2.1.4	There are written and dated specific job descriptions for all categories of staff that include: a) qualifications, training, and experience required for the position; b) lines of authority; c) accountability, functions and responsibilities; d) reviewed when required and when there is a major change in any of the following: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required v) staffing patterns; vi) Statutory Regulations. <table><tr><td rowspan="4">EVIDENCE OF COMPLIANCE</td><td>1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (d).</td><td></td></tr><tr><td>2. Job description includes specialisation skills.</td><td></td></tr><tr><td>3. Relevant authorisation granted where applicable (e.g. operating specialised equipment</td><td></td></tr><tr><td>4. The job description is acknowledged by the staff and signed by the Head of Service and dated.</td><td></td></tr></table> Facility Comments:	EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (d).		2. Job description includes specialisation skills.		3. Relevant authorisation granted where applicable (e.g. operating specialised equipment		4. The job description is acknowledged by the staff and signed by the Head of Service and dated.				
EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (d).												
	2. Job description includes specialisation skills.												
	3. Relevant authorisation granted where applicable (e.g. operating specialised equipment												
	4. The job description is acknowledged by the staff and signed by the Head of Service and dated.												
20.2.1.5	Personnel records on training, staff development, leave and others are maintained for every staff. Note: Staff personal record may be kept in Human Resource Department as per Facility policy.												

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	EVIDENCE OF COMPLIANCE	1. Staff personal records include:				
		a) staff biodata;				
		b) qualification and experience;				
		c) training records on infection control, and technical aspects, e.g. spillage management, safety and health;				
		d) competency record and authorisation for specialised equipment;				
		e) leave record;				
		f) confidentiality agreement;				
		g) immunisation records.				
Facility Comments:						
20.2.1.6 CORE	Provision of vaccination programmes for all staff exposed to sharps injury and biological hazards.					
	EVIDENCE OF COMPLIANCE	1. Vaccination programme				
		2. Vaccination records				
	Facility Comments:					
20.2.1.7 CORE	There is a structured orientation programme where new staff are briefed on their services, operational policies and relevant aspects of the Facility to prepare them for their roles and responsibilities.					
	EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme.				
		2. Records on structured orientation programme				
		3. Orientation Brief				
		4. List of attendance				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
20.2.1.8	There is evidence of training needs assessment and staff development plan which provides the knowledge and skills required for staff to maintain competency in their current positions and future advancement.					
	EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and gaps identified.				
		2. A staff development plan based on training needs assessment is available.				
		3. Training schedule/calendar is in place.				
		4. Training module				
	Facility Comments:					
20.2.1.9	There are continuing education activities for staff to pursue professional interests and to prepare for current and future changes in practice.					
	EVIDENCE OF COMPLIANCE	1. Continuing education activities and schedule				
		2. Contents of training programme				
		3. Training records on continuing education activities are kept and maintained for each staff.				
		4. Certificate of attendance				
	Facility Comments:					
20.2.1.10	Staff receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.					
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff is completed upon probationary period and as an annual exercise.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT								
TOPIC 20.3:		<u>POLICIES AND PROCEDURES</u>						
STANDARD <u>20.3.1</u>		<i>There are documented policies and procedures that reflect current knowledge and practice of the services and are consistent with the goals and objectives of the Housekeeping Services and relevant regulations and statutory requirements.</i>						
		CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
20.3.1.1 CORE	There are written policies and procedures for the Housekeeping Services which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated.							
	There is a mechanism for and evidence of a periodic review at least once in every three years.							
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for the service.						
		2. Policies and procedures are consistent with regulatory requirements and current standard practices.						
		3. Evidence of periodic review of policies and procedures.						
		4. The policies and procedures are endorsed and dated.						
	Facility Comments:							
20.3.1.2	Policies and procedures are developed by a committee in collaboration with staff, Infection Control Committee, Management and where required with other external service providers and with reference to relevant sources involved. Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.							
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.						
		2. Minutes of meeting with evidence of cross reference with other departments						
		3. Documented cross departmental policies						
	Facility Comments:							

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
20.3.1.3	Current policies and procedures are communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings				
		2. Circulation list and acknowledgement				
	Facility Comments:					
20.3.1.4 CORE	There is evidence of compliance with policies and procedures.					
	EVIDENCE OF COMPLIANCE	1. Compliance with policies and procedures through:				
		a) interview of staff on practices;				
		b) verify with observation on practices;				
		c) results of audit on practices;				
		d) practices in line with established policies and procedures.				
	Facility Comments:					
20.3.1.5	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.					
	EVIDENCE OF COMPLIANCE	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.				
Facility Comments:						
20.3.1.6	Policies and procedures for the Housekeeping Services shall include the following:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	a) routine and special-purpose cleaning; b) colour coding for cleaning material/apparatus; c) provision of designated staff for specific areas such as emergency rooms, labour-delivery rooms, nurseries, surgical suites, critical care units, intensive care units, recovery rooms etc; d) the use, cleaning and care of equipment; e) the measurement, labeling, storage, and proper use of housekeeping chemicals and cleaning supplies including germicides; f) evaluation of cleaning effectiveness; g) collection, segregation and disposal of waste according to statutory requirements; h) safety and health aspects, e.g. use of personal protective equipment (PPE).			
	1. Policies and procedures on Housekeeping Services that address but not limited to items (a) to (h) are available.			
	2. Written instructions on the following:-			
	a) routine and special-purpose cleaning, e.g. isolation room (negative and positive pressure), critical areas, e.g. operating theatre, nursery, haemodialysis unit etc;			
	b) prohibition of dry dusting and sweeping in the hospital;			
	c) colour coding of mops and other cleaning materials;			
	d) cleansing schedule with frequency;			
	e) list of chemicals recommended by Hospital Infection and Antibiotic Control Committee;			
	f) audit and inspection procedures;			
	g) collection route for general and hazardous waste and designated dump sites;			
	h) segregation of solid waste, if applicable.			
	Facility Comments:			
20.3.1.7	Storage areas comply with Safety Programmes and Fire Safety requirements as in the Environmental and Safety Services, Standard No.2.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	EVIDENCE OF COMPLIANCE	1. Policy on handling and storage of chemicals as per regulatory requirement and standards i.e. Department of Occupational Safety and Health (DOSH) requirements.					
		2. Dedicated chemical storage areas with good ventilation system, washing facilities and appropriate Personal Protective Equipment (PPE).					
	Facility Comments:						

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 20.4: <u>FACILITIES AND EQUIPMENT</u> STANDARD 20.4.1 <i>There are safe and adequate facilities and equipment to enable the Housekeeping Services to meet its goals and objectives and ensuring patient and staff safety.</i>						
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
20.4.1.1	There are adequate and appropriate facilities and equipment with proper utilisation of space to enable staff to carry out their professional and administrative functions.					
	EVIDENCE OF COMPLIANCE	1. Adequate and proper utilisation of space:				
		a) adequate storage space;				
		b) dedicated routes for waste collection;				
		c) designated wash and drying areas for mop heads.				
		2. Appropriate type of equipment:				
		a) adequate and appropriate PPE for housekeeping staff;				
		b) covered housekeeping trolley.				
		3. Easy access and clear exit routes				
		4. Absence of overcrowding				
5. Appropriate staff change rooms with shower and lockers						
Facility Comments:						
20.4.1.2	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.					
	EVIDENCE OF COMPLIANCE	1. Testing, commissioning and calibration records (certificates or stickers)				
		2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as evidence of compliance to the relevant standards and Acts.				
		Facility Comments:				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
20.4.1.3 CORE	There is evidence that the facility has a comprehensive maintenance programme such as planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.				
	EVIDENCE OF COMPLIANCE	1. Planned Preventive Maintenance records such as schedule, stickers, etc.			
		2. Calibration records			
		3. Planned Replacement Programme where applicable			
		4. Repair and maintenance records			
		5. Asset inventory/master list of equipment			
	Facility Comments:				
20.4.1.4	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.				
	EVIDENCE OF COMPLIANCE	1. User training records			
		2. Competency assessment record			
		3. Letter of authorisation			
		4. List of staff trained and authorised to operate specialised equipment			
	Facility Comments:				
20.4.1.5 CORE	Solution, cleaning chemicals and hazardous substances shall be properly labeled and stored in safe places as per Material Safety Data Sheet (MSDS) or Chemical Safety Data Sheet.				
	EVIDENCE OF COMPLIANCE	1. MSDS records			
		2. Chemical master list			
		3. Chemical store with washing facilities and adequate ventilation.			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT								
TOPIC 20.5:		<u>SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES</u>						
STANDARD <u>20.5.1</u>		<i>The Head of Housekeeping Services shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Housekeeping Services.</i>						
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS				
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING			
20.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Housekeeping Services. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.							
	EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to (f).						
		2. Records on performance improvement activities.						
		3. Minutes of performance improvement meetings						
		4. Performance improvement studies						
		5. Records on innovation if available						
	Facility Comments:							
20.5.1.2	The Head of Housekeeping Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement to appropriate individual/personnel within the respective services.							

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes of meetings				
		2. Letter of assignment of responsibilities				
		3. Job description				
	Facility Comments:					
20.5.1.3	The Head of the Housekeeping Services shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility. Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.					
	EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:				
		a) Training of staff				
		b) Policy on incident reporting				
		c) Methodology of incident reporting				
		d) Register/records of incidents				
		2. Completed incident reports				
		3. Root Cause Analysis				
		4. Corrective and preventive action plans				
		5. Remedial measure				
		6. Minutes of meetings				
		7. Acknowledgment by Head of Service and PIC/Hospital Director				
		8. Feedback given to staff regarding incident reporting.				
	Facility Comments:					
20.5.1.4 CORE	There is tracking and trending of specific performance indicators not limited to but at least two (2) of the following: a) trend of performance score during in-house inspection/joint inspection (Target: 80% with minimum score of 3)					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	b) customer satisfaction feedback (Target: 80% satisfaction)					
	EVIDENCE OF COMPLIANCE				1. Specific performance indicators monitored.	
					2. Records on tracking and trending analysis.	
					3. Remedial measures taken where appropriate.	
	Facility Comments:					
20.5.1.5	Feedback on results of safety and performance improvement activities are regularly communicated to the staff and relevant authority.					
	EVIDENCE OF COMPLIANCE				1. Results on safety and performance improvement activities are accessible to staff.	
					2. Evidence of feedback via communication on results of performance improvement activities through continuing education activities/meetings.	
					3. Minutes of service/unit/committee meetings	
	Facility Comments:					
20.5.1.6	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.					
	EVIDENCE OF COMPLIANCE				1. Documentation on performance improvement activities and performance indicators.	
					2. Policy statement on anonymity on patients and providers involved in performance improvement activities.	
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
20.5.1.7 CORE	There are safety and performance improvement activities that address staff safety of the outsourced service providers.					
	EVIDENCE OF COMPLIANCE	1. Staff health screening				
		2. Identification of health risk factors				
		3. Infectious diseases prevention programme/activities				
		4. Anti-smoking programme				
		5. Healthy life style campaign				
		6. Staff training on:				
		a) sharps and needle stick injury management;				
		b) Occupational Safety and Health;				
		c) ergonomics;				
		d) biohazard waste disposal.				
		7. Medical check-up record				
		8. Post exposure management				
		9. Universal/standard precautions				
	Facility Comments:					

SERVICE SUMMARY	
SURVEYOR SUMMARY:	
OVERALL RATING:	
OVERALL RISK:	

SURVEY ITEM & SELF-ASSESSMENT							
SERVICE STANDARD 21 : LINEN SERVICES							
	<u>PREAMBLE</u> <i>The Linen Services include the supply and delivery of clean linen and the collection and washing of dirty and soiled linen. Linen Services may be provided from within the Facility by either own staff or contract staff. The services may also be contracted to a qualified external contractor where the MSQH standards and criteria for Accreditation purposes including standards for Prevention and Control of Infection and Housekeeping Services shall apply.</i>						
<u>TOPIC 21.1:</u> <u>STANDARD 21.1.1</u>	<u>ORGANISATION AND MANAGEMENT</u> <i>The Linen Services are organised and administered to provide a full range of clean linen for the optimum care for patients according to the goals and objectives of the Facility.</i>						
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
21.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Linen Services are clearly documented and measurable. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.						
	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.					
		2. Goals and objectives of the Linen Services in line with the Facility statements are available, endorsed and dated.					
		3. Evidence of planned reviews of the above statements.					
		4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc).					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.				
	Facility Comments:				
21.1.1.2 CORE	There is an organisation chart which: a) provides a clear representation of the structure, function and reporting relationships between the Head and the staff of the Linen Services; b) is accessible to all staff and clients; c) includes off-site services if applicable; d) is revised when there is a major change in any of the following: i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns.				
	EVIDENCE OF COMPLIANCE				
	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Head and the staff of the Linen Services.				
	2. Organisation chart of the service is endorsed, dated and accessible.				
	3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).				
	Facility Comments:				
21.1.1.3	Regular staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Linen Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes are accessible, disseminated and acknowledged by the staff.				
		2. Attendance list of members with adequate representatives of the service.				
		3. Frequency of meetings as scheduled.				
		4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).				
	Facility Comments:					
21.1.1.4	The Head of Linen Services is involved in the planning, justification and management of the budget and resource utilisation of the services.					
	EVIDENCE OF COMPLIANCE	1. Minutes of Facility-wide management meeting				
		2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service.				
		3. Approved budget and resources.				
	Facility Comments:					
21.1.1.5	The Head of Linen Services is involved in the appointment and/OR assignment of staff.					
	EVIDENCE OF COMPLIANCE	1. Records on staff interview (if applicable)				
		2. Appointment/assignment letter of Head of Service				
		3. Job description of Head of Service				
		4. Records on staff deployment				
		5. Duty roster				
	Facility Comments:					
21.1.1.6	Appropriate statistics and records shall be maintained in relation to the provision of Linen Services and used for managing the services and patient care purposes.					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Records are available but not limited to the following:			
		a) workload/census;			
		b) annual report;			
		c) accident/incident reports;			
		d) staffing number and staff profile;			
		e) staff training records;			
		f) data on performance improvement activities, including performance indicators;			
		g) linen inventory ;			
		h) customer feedback;			
		i) off-site laundry plant audit inspection records.			
	Facility Comments:				
21.1.1.7 CORE	Where services are provided by an external source there is a written agreement between the external service provider and the Facility stating the requirements for service delivery, including the following: a) formal lines of communication and responsibilities between the external service provider and the Facility; b) regular site inspection shall be conducted by the licensee to ensure compliance to laundry standards as stipulated; c) provision of adequate numbers of appropriately qualified personnel to perform their duties; d) participation, as appropriate, of the external service provider in committees of the Facility i.e. Prevention and Control of Infection; e) arrangement for adequate pickup and delivery; f) arrangements for after-hours and emergency services; g) mechanisms for dealing with problems in service delivery; h) adequate facilities and equipment for providing the services at the Facility and at the site of the external service for washing, ironing, storage and issuance of linen supplies;				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	i) involvement of the external service provider in safety and performance improvement activities of the Facility, as appropriate; j) comply with the appropriate MSQH Standards of Accreditation for Linen Services which functions within the Facility.					
	EVIDENCE OF COMPLIANCE	1. Written agreement which include (a) to (j) between the external service provider and the Facility is endorsed, signed and dated.				
		2. Delivery and collection schedule.				
	Facility Comments:					
21.1.1.8 CORE	Where services are provided by an external source, the Person In Charge (PIC) of the Facility shall appoint a person to supervise, monitor and provide technical input to the Linen Services.					
	EVIDENCE OF COMPLIANCE	1. Appointment/assignment letter of liaison officer with terms of reference.				
		2. Job description				
	Facility Comments:					

SURVEY ITEM &SELF-ASSESSMENT							
<u>TOPIC 21.2</u>		<u>HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT</u>					
<u>STANDARD 21.2.1</u>		<i>The Linen Services shall be directed and adequately staffed with appropriately qualified and trained personnel to achieve the goals and objectives of the Linen Services.</i>					
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
21.2.1.1	The Head and staff of the Linen Services shall be individuals qualified by education, training, and experience to commensurate with the requirements of the various positions.						
	EVIDENCE OF COMPLIANCE	1. Records on qualification and experience of Head of Service and staff related to linen services					
		2. Appointment/assignment letters					
		3. Training and competency records					
	Facility Comments:						
21.2.1.2	The authority, responsibilities and accountabilities of the Head of Linen Services are clearly delineated and documented.						
	EVIDENCE OF COMPLIANCE	1. Appointment /assignment letter for Head of Service.					
		2. Description of duties and responsibilities					
	Facility Comments:						
21.2.1.3	Sufficient numbers of personnel and support staff with appropriate qualifications and experience are employed to meet the need of the services.						

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Number of staff and qualification should commensurate with workload.				
		2. Staffing pattern				
		3. Duty roster				
		4. Census on workload				
		Facility Comments:				
21.2.1.4	There are written and dated specific job descriptions for all categories of staff that include: a) qualifications, training and experience required for the position; b) lines of authority; c) accountability, functions and responsibilities; d) reviewed when required and when there is a major change in any of the following: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations.					
	EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (d).				
		2. Job description includes specialisation skills				
		3. Relevant authorisation granted where applicable (e.g. operating specialised equipment)				
		4. The job description is acknowledged by the staff and signed by the Head of Service and dated.				
	Facility Comments:					
21.1.1.5	Personnel records on training, staff development, leave and others are maintained for every staff.					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	Note: Staff personal record may be kept in Human Resource Department as per Facility policy.					
	EVIDENCE OF COMPLIANCE	1. Staff personal records include:				
		a) staff biodata;				
		b) qualification and experience;				
		c) training records on infection control and technical aspects, e.g. safety and health;				
		d) competency records and authorisation to operate specialised equipment;				
		e) leave record;				
		f) confidentiality agreement.				
		g) immunisation record				
	Facility Comments:					
21.2.1.6 CORE	Provision of vaccination programmes for all staff exposed to sharps injury and biological hazards.					
	EVIDENCE OF COMPLIANCE	1. Vaccination programme				
		2. Vaccination records				
	Facility Comments:					
21.2.1.7	There is a structured orientation programme where new staff are briefed on their services, operational policies and relevant aspects of the Facility to prepare them for their roles and responsibilities.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme.					
		2. Records on structured orientation programme					
		3. Orientation Brief					
		4. List of attendance					
	Facility Comments:						
21.2.1.8	EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and gaps identified.					
		2. A staff development plan based on training needs assessment is available.					
		3. Training schedule/calendar is in place.					
		4. Training module					
	Facility Comments:						
21.2.1.9	EVIDENCE OF COMPLIANCE	1. Continuing education activities and schedule					
		2. Contents of training programme					
		3. Training records on continuing education activities are kept and maintained for each staff.					
		4. Certificate of attendance					
	Facility Comments:						
21.2.1.10	Staff receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.						

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff is completed upon probationary period and as an annual exercise.				
	Facility Comments:					

SURVEY ITEM &SELF-ASSESSMENT					
TOPIC 21.3:		<u>POLICIES AND PROCEDURES</u>			
STANDARD <u>21.3.1</u>		<i>There are documented policies and procedures that reflect current knowledge and practice of Linen Services and they are consistent with the goals and objectives of the Linen Services and relevant regulations and statutory requirements.</i>			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
21.3.1.1 CORE	There are written policies and procedures for the Linen Services which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated.				
	There is a mechanism for and evidence of a periodic review at least once in every three years.				
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for the service.			
		2. Policies and procedures are consistent with regulatory requirements and current standard practices.			
		3. Evidence of periodic review of policies and procedures.			
		4. The policies and procedures are endorsed and dated.			
Facility Comments:					
21.3.1.2	Policies and procedures are developed in collaboration with staff, Infection Control Committee, Management and where required with other external service providers and with reference to relevant sources involved. Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.				
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.			
		2. Minutes of meeting with evidence of cross reference with other departments			
		3. Documented cross departmental policies			
		Facility Comments:			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
21.3.1.3	Current policies and procedures are communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings				
		2. Circulation list and acknowledgement				
	Facility Comments:					
21.3.1.4 CORE	There is evidence of compliance with policies and procedures.					
	EVIDENCE OF COMPLIANCE	1. Compliance with policies and procedures through:				
		a) interview of staff on practices;				
		b) verify with observation on practices;				
		c) results of audit on practices;				
		d) practices in line with established policies and procedures .				
	Facility Comments:					
21.3.1.5	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.					
	EVIDENCE OF COMPLIANCE	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT							
STANDARD 21.3.2		There is adequate supply of clean linen and protective clothing. They are properly handled and stored in such a way as to avoid re-absorption of moisture and contamination from surface contact or airborne. All protective clothing will be considered as linen.					
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
21.3.2.1 CORE	The patient shall not be in soiled linen under any circumstances.						
	EVIDENCE OF COMPLIANCE	1. Policy on Linen supply					
		2. Patients have clean linen as evidenced on-site.					
	Facility Comments:						
21.3.2.2 CORE	Soiled linen is collected in such a manner as to avoid microbial dissemination and it is placed in segregated bags or containers at the site of collection.						
	EVIDENCE OF COMPLIANCE	1. Policy and procedure on collection and placement of soiled					
		2. Soiled linen is collected in closed colour coded linen bag as observed on inspection.					
		3. Adequate supply of alginate bag for infectious linen.					
	Facility Comments:						
21.3.2.3 CORE	Soiled linen from infectious patients is clearly identified; staff shall take appropriate precautions in handling and processing this type of linen.						
	EVIDENCE OF COMPLIANCE	1. Policy and procedure on handling infectious linen					
		2. Use of colour coded linen bag for different types of linen hospital wide					
		3. Use of alginate bag for infectious linen as evidenced on site					
	Facility Comments:						

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
21.3.2.4 CORE	Written procedures are in accordance with acceptable standards for handling and processing linen and shall cover the following: a) processing techniques including handling and collecting of dirty linen prior to washing; b) wash formula (for example, linen load quantity, time duration, water temperature, use of bleach, final water pH); c) physical appearance and condition of linen.			
	EVIDENCE OF COMPLIANCE			
	1. Policies and Procedures on Linen Services that address but not limited to items (a) to (c) are available.			
	Facility Comments:			
21.3.2.5 CORE	Containers transporting soiled linen bags and storage areas for soiled linen are cleaned according to agreed schedule.			
	EVIDENCE OF COMPLIANCE			
	1. Policy and procedure on handling containers for transporting			
	2. Schedule on cleaning linen transporting containers.			
21.3.2.6 CORE	Clean linen is transported and stored separately from soiled linen.			
	EVIDENCE OF COMPLIANCE			
	1. Policy and procedure on transporting and storing of clean linen			
	2. Schedule on cleaning containers used for transporting clean linen			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		3. Records on cleaning containers used for transporting clean linen.				
		4. Dedicated clean linen storage area.				
	Facility Comments:					
21.3.2.7 CORE	In-house facilities for handling and processing of soiled linen are separated from the clean linen processing area, patient rooms, areas of food preparation and storage, and areas where clean material and equipment are stored.					
	EVIDENCE OF COMPLIANCE	1. Dedicated area for handling and processing of soiled linen				
		2. Compliance to policies and procedures on in-house processing of linen				
	Facility Comments:					
21.3.2.8	Smoking is prohibited in areas for handling linen.					
	EVIDENCE OF COMPLIANCE	1. 'No Smoking' signage displayed.				
		2. Policy on smoking prohibition.				
	Facility Comments:					
21.3.2.9	Surfaces and overhead areas in the laundry and central linen storage area are cleaned as to agreed schedule.					
	EVIDENCE OF COMPLIANCE	1. Cleaning schedule for laundry and storage area surfaces including overhead areas.				
		2. Clean surfaces/environment in laundry and linen storage area evidenced upon onsite inspection.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
21.3.2.10	The laundry area and central linen storage area are planned and equipped to prevent the dissemination of contaminants, and there is good exhaust ventilation with airflow from clean to soiled areas.					
	EVIDENCE OF COMPLIANCE	1. As built drawing of laundry/design meets relevant standards.				
		2. Work process prevents dissemination of contaminants.				
		3. Ventilation with airflow from clean to soiled areas.				
	Facility Comments:					
21.3.2.11	To minimise the risk of cross infection, hand hygiene facilities are readily available in the clean and soiled linen areas. Staff are required to put on appropriate personal protective equipment in the soiled area.					
	EVIDENCE OF COMPLIANCE	1. Separate hand washing facilities in soiled linen and clean linen areas.				
		2. Appropriate Personal Protective Equipment (PPE) available.				
		3. Counting of soiled linen prohibited as per policy/work instruction				
	Facility Comments:					

SURVEY ITEM &SELF-ASSESSMENT									
TOPIC 21.4:		<u>FACILITIES AND EQUIPMENT</u>							
STANDARD 21.4.1		<i>There are safe and adequate facilities and equipment to enable the Linen Services to meet its goals and objectives and ensuring patient and staff safety.</i>							
	CRITERIA FOR COMPLIANCE:				SELF RATING	SURVEYOR FINDINGS			
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
21.4.1.1	There are adequate and appropriate facilities and equipment with proper utilisation of space to enable staff to carry out their professional and administrative functions.								
	EVIDENCE OF COMPLIANCE	1. Adequate and proper utilisation of space:							
		a) separate entrance for clean and soiled linen;							
		b) adequate linen storage space.							
		2. Appropriate type of equipment:							
		a) appropriate personal protective equipment available for Linen Services staff							
		3. Easy access and clear exit routes							
		4. Appropriate staff change rooms with showers and lockers							
	Facility Comments:								
21.4.1.2	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.								
	EVIDENCE OF COMPLIANCE	1. Testing, commissioning and calibration records (certificates or stickers)							
		2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as evidence of compliance to the relevant standards and Acts.							
	Facility Comments:								

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
21.4.1.3 CORE	There is evidence that the facility has a comprehensive maintenance programme such as planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.					
	EVIDENCE OF COMPLIANCE	1. Planned Preventive Maintenance records such as schedule, stickers, etc.				
		2. Calibration records				
		3. Planned Replacement Programme where applicable				
		4. Repair and maintenance records				
		5. Asset inventory/master list of equipment				
	Facility Comments:					
21.4.1.4	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.					
	EVIDENCE OF COMPLIANCE	1. User training records (on-site laundry service)				
		2. Competency assessment record				
		3. Letter of authorisation				
		4. List of staff trained and authorised to operate specialised equipment				
	Facility Comments:					
21.4.1.5	There are appropriate arrangements made for the disposal of waste water and chemical detergent from laundry plant to sewage system.					
	EVIDENCE OF COMPLIANCE	1. Drainage drawing on disposal of waste water and chemical detergent from laundry plant to sewage system.				
		2. Appropriateness of disposal of waste water and chemical detergent as observed onsite.				
	Facility Comments:					

SURVEY ITEM &SELF-ASSESSMENT						
TOPIC 21.5:		<u>SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES</u>				
<u>STANDARD 21.5.1</u>		<i>The Head of Linen Services shall ensure the provision of quality performance with staff involvement in the continuous safety and quality improvement activities of the Linen Services.</i>				
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
21.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Linen Services. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.					
	EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to (f)				
		2. Records on performance improvement activities.				
		3. Minutes of performance improvement meetings				
		4. Performance improvement studies				
		5. Records on innovation if available				
	Facility Comments:					
	21.5.1.2	The Head of Linen Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement to appropriate individual/personnel within the respective services.				
EVIDENCE OF COMPLIANCE		1. Minutes of meetings				
		2. Letter of assignment of responsibilities				
		3. Job description				
Facility Comments:						

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
21.5.1.3	The Head of the Linen Services shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility.				
	Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.				
	EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:			
		a) Training of staff			
		b) Policy on incident reporting			
		c) Methodology of incident reporting			
		d) Register/records of incidents			
		2. Completed incident reports			
		3. Root Cause Analysis			
		4. Corrective and preventive action plans			
		5. Remedial measure			
	6. Minutes of meetings				
	7. Acknowledgment by Head of Service and PIC/Hospital Director				
	8. Feedback given to staff regarding incident reporting.				
Facility Comments:					
21.5.1.4 CORE	There is tracking and trending of specific performance indicators not limited to but at least two (2) of the following:				
	a) percentage of linen shortfall (Target: 2%) b) linen rejection rate (Target: below 2%)				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	c) percentage of incidents reported monthly that have had Root Cause Analysis (RCA) done and action taken to prevent recurrence (Target: 100%)					
	d) Internal customer satisfaction survey (Target: 80% satisfaction)					
	EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored.				
		2. Records on tracking and trending analysis.				
		3. Remedial measures taken where appropriate				
Facility Comments:						
21.5.1.5	Feedback on results of safety and performance improvement activities are regularly communicated to the staff and relevant authority.					
	EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff.				
		2. Evidence of feedback via communication on results of performance improvement activities through continuing education activities/meetings.				
		3. Minutes of service/unit meetings				
	Facility Comments:					
21.5.1.6	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.					
	EVIDENCE OF COMPLIANCE	1. Documentation on performance improvement activities and performance indicators.				
		2. Policy statement on anonymity on patients and providers involved in performance improvement activities.				
	Facility Comments:					

SERVICE SUMMARY	
SURVEYOR SUMMARY:	
OVERALL RATING:	
OVERALL RISK:	

SURVEY ITEM & SELF-ASSESSMENT					
SERVICE STANDARD 22 : FOOD SERVICES					
	<u>PREAMBLE</u> <i>The Food Services shall be Headed by a Qualified Food Service Officer registered with the Malaysian Allied Health Professions Council and shall encompass the planning and provision of in-house and outsource Food Service of normal diets according to needs and requirements of patients. Food Services shall also prepare and deliver therapeutic diets for individual patients requiring therapeutic diet including individualized medical nutrition therapy as prescribed by the medical practitioner and dietitian based on established standards of practice and professional performance.</i> <i>Components of such services may be provided by one department or through separate entities and contracts:</i> <i>1. Inpatient Food Services</i> <i>2. Cafeteria/Food Court/Food Outlets/ Vending Machines</i>				
<u>TOPIC 22.1:</u>	<u>ORGANISATION AND MANAGEMENT</u>				
<u>STANDARD 22.1.1</u>	<i>Food Services shall be organised and coordinated with other services to provide safe, healthy and nutritious food for patients, staff and the public, in accordance with the overall objectives of the Facility.</i> <i>Components of such services may be provided by one department or through separate entities. In some instances, these services may be provided by external sources.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
22.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Food Services are clearly documented and measurable. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.				
	EVIDENCE OF COMPLIANCE				
	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.				
	2. Goals and objectives of the Food Services in line with the Facility statements are available, endorsed and dated.				
	3. Evidence of planned reviews of the above statements.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)				
		5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.				
	Facility Comments:					
22.1.1.2 CORE	There is an organisation chart which:					
	a) provides a clear representation of the structure, function and reporting relationships between the Head and the staff of the Food Services;					
	b) is accessible to all staff and clients;					
	c) includes off-site services if applicable;					
	d) is revised when there is a major change in any of the following:					
		i) organisation;				
		ii) functions;				
		iii) reporting relationships;				
		iv) staffing patterns.				
	EVIDENCE OF COMPLIANCE	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Head and the staff of the Food Services.				
		2. Organisation chart of the service is endorsed, dated and accessible.				
		3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).				
	Facility Comments:					
22.1.1.3	Regular staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Food Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes are accessible, disseminated and acknowledged by the staff.				
		2. Attendance list of members with adequate representatives of the service.				
		3. Frequency of meetings as scheduled.				
		4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).				
	Facility Comments:					
22.1.1.4 CORE	The Head of the Food Services shall be a Qualified Food Service Officer and involved in the planning, management, and justification of budget and resource utilisation of the services. Note: For district healthcare facility, the visiting dietitian shall be responsible and accountable for the monitoring of Therapeutic Diet and Enteral Product.					
	EVIDENCE OF COMPLIANCE	1. Minutes of Facility-wide management meeting				
		2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc.) for the service.				
		3. Approved budget and resources.				
		4. Letter of Appointment of Head of Food Services				
	Facility Comments:					
22.1.1.5	The Head of Food Services is involved in the appointment and/or assignment of staff.					
	EVIDENCE OF COMPLIANCE	1. Records on staff interview (if applicable)				
		2. Assignment letter of Head of Service				
		3. Job description				
		4. Records on staff deployment				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	5. Duty roster				
	Facility Comments:				
22.1.1.6	Appropriate statistics and records shall be maintained in relation to the provision of Food Services and used for managing the services and patient care purposes. Information on the number of meals provided (normal and therapeutic diets) and unit costs is kept.				
	EVIDENCE OF COMPLIANCE				
	1. Records are available but not limited to the following:				
	a) workload/meals provided;				
	b) food costing;				
	c) annual report;				
	d) accident/incident reports;				
	e) staffing number and staff profile;				
	f) staff training records;				
	g) data on performance improvement activities, including performance indicators.				
	Facility Comments:				
22.1.1.7	The quantity, quality, and variety of food offered shall be appropriate to patients and staff and also meet their nutritional and food safety requirements, as well as religious and cultural preferences. The following certifications are encouraged:				
	1. Good Manufacturing Practice (GMP) certification				
	2. Hazard Analysis Critical Control Point (HACCP)				
	3. Halal certification				
	EVIDENCE OF COMPLIANCE				
	1. GMP certification				
	2. HACCP certification				
	3. Cycle/Choice Menus				
	4. Halal certification				
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS									
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING								
22.1.1.8	Menu Engineering and Planning Committee (Dietetic And Foodservice staff) shall be involved in the following aspects of food services to patients: a) formulation of menus and recipes; b) continuous training and education for food services staff. <table><tr><td rowspan="3">EVIDENCE OF COMPLIANCE</td><td>1. Minutes of Menu Committee meeting</td><td></td></tr><tr><td>2. Cycle/Choice Menus</td><td></td></tr><tr><td>3. Training records</td><td></td></tr></table> Facility Comments:	EVIDENCE OF COMPLIANCE	1. Minutes of Menu Committee meeting		2. Cycle/Choice Menus		3. Training records					
EVIDENCE OF COMPLIANCE	1. Minutes of Menu Committee meeting											
	2. Cycle/Choice Menus											
	3. Training records											
22.1.1.9 CORE	Where Food Services are provided by an external source, there is a written agreement between the external service provider and the Facility stating the requirements for the services that include the following: a) valid license from the local authorities; b) formal lines of communication and responsibilities between the external service provider and the Facility; c) external service provider contracts are monitor and evaluated by an employed on-site Food Service Officer and Dietitian where appropriate; d) provision of safe and nutritious food in a recommended quantity to meet the nutritional requirements, religious and cultural preferences; e) participation of the external service provider in appropriate committees of the Facility; f) arrangements for after-hours and emergency services; g) involvement of the external service provider in safety and quality improvement activities of the Facility, as appropriate; h) space, facilities and equipment are provided by the Facility. <table><tr><td rowspan="5">EVIDENCE OF COMPLIANCE</td><td>1. Terms of written Agreement include items (a) to (h) and evidence of compliance.</td><td></td></tr><tr><td>2. License from local authority, e.g. local health department.</td><td></td></tr><tr><td>3. Halal certification</td><td rowspan="3">if included in the terms of the contract</td></tr><tr><td>4. GMP certification</td></tr><tr><td>5. HACCP certification</td></tr></table>	EVIDENCE OF COMPLIANCE	1. Terms of written Agreement include items (a) to (h) and evidence of compliance.		2. License from local authority, e.g. local health department.		3. Halal certification	if included in the terms of the contract	4. GMP certification	5. HACCP certification		
EVIDENCE OF COMPLIANCE	1. Terms of written Agreement include items (a) to (h) and evidence of compliance.											
	2. License from local authority, e.g. local health department.											
	3. Halal certification		if included in the terms of the contract									
	4. GMP certification											
	5. HACCP certification											

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		6. Minutes of meeting				
	Facility Comments:					

SURVEY ITEM &SELF-ASSESSMENT						
<u>TOPIC 22.2</u>		<u>HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT</u>				
<u>STANDARD 22.2.1</u>		<i>The Food Services is managed by Qualified Food Service Officer and staffed by appropriately qualified staff to achieve the goals and objectives of the Food Services; and to ensure competency in handling, preparing, serving of food including supervision and management of food handlers.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
22.2.1.1	The Head and staff of the Food Services shall be individuals qualified by education, training, experience and certification to commensurate with the requirements of the various positions. The Head of Food Services shall be registered following the requirements of the Allied Health Professions Act					
	EVIDENCE OF COMPLIANCE	1. Records on credentials of Head of Service and staff required to fill up the posts within the service (to match the complexity of the Facility and services) and certification/registration.				
		2. Appointment/assignment letters				
		3. Certification				
		4. Training and competency records				
	Facility Comments:					
22.2.1.2 CORE	The Person In Charge (PIC) of the Facility shall ensure the availability of a Qualified Dietitian who shall be responsible to evaluate the therapeutic diet and enteral product in district healthcare facility without resident Qualified Dietitian.					
	EVIDENCE OF COMPLIANCE	1. Appointment/approval letter of visiting dietitian				
		2. Attendance and record of visits by visiting dietitian				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
22.2.1.3	The authority, responsibilities and accountabilities of the Head of Food Services are clearly delineated and documented.			
	EVIDENCE OF COMPLIANCE			
	1. Appointment/assignment letter for Head of Service.			
	2. Description of duties and responsibilities.			
	Facility Comments:			
22.2.1.4	Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the need of the services.			
	There shall be regular review of staffing needs and staff utilisation.			
	EVIDENCE OF COMPLIANCE			
	1. Number of staff and qualification commensurate with workload.			
	2. Staffing pattern and review of staffing needs			
	3. Duty roster			
	4. Census and statistics			
	Facility Comments:			
22.1.1.5	There are written and dated specific job descriptions for all categories of staff that include: a) qualifications, training, experience and certification required for the position; b) lines of authority; c) accountability, functions and responsibilities; d) reviewed when required and when there is a major change in any of the following: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (d).				
		2. Job description includes specialisation skills				
		3. Relevant privileges granted where applicable				
		4. The job description is acknowledged by the staff and signed by the Head of Service and dated.				
	Facility Comments:					
22.2.1.6	Personnel records on training, staff development, leave and others are maintained for every staff. Note: Staff personal record may be kept in Human Resource Department as per Facility policy.					
	EVIDENCE OF COMPLIANCE	1. Staff personal records include:				
		a) staff biodata;				
		b) qualification and experience;				
		c) evidence of current registration;				
		d) training record;				
		e) competency record				
		f) leave record;				
		g) confidentiality agreement.				
	Facility Comments:					
22.2.1.7	There is a structured orientation programme where new staff are briefed on their services, operational policies and relevant aspects of the Facility to prepare them for their roles and responsibilities.					
	EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme.				
		2. Records on structured orientation programme				
		3. Orientation Brief				
		4. List of attendance				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
22.2.1.8	There is evidence of training needs assessment and staff development plan which provides the knowledge and skills required for staff to maintain competency in their current positions and future advancement.				
	EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and gaps identified.			
		2. A staff development plan based on training needs assessment is available.			
		3. Training schedule/calendar is in place.			
		4. Training module			
	Facility Comments:				
22.2.1.9	There are continuing education activities for staff to pursue professional interests and to prepare for current and future changes in practice.				
	EVIDENCE OF COMPLIANCE	1. Continuing education activities schedule			
		2. Contents of training programme			
		3. Training records on continuing education activities are kept and maintained for each staff.			
		4. Certificate of attendance/degree/post basic training.			
	Facility Comments:				
22.2.1.10	Staff receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.				
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff is completed upon probationary period and as an annual exercise.			
		Facility Comments:			
22.2.1.11 CORE	All food handlers shall undergo medical screening, immunisation and Food Handler Training as required by relevant statutory requirements.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Pre-employment medical checkup record				
		2. Immunisation record (Typhoid)				
		3. Food Handlers Certificate				
	Facility Comments:					

SURVEY ITEM &SELF-ASSESSMENT						
TOPIC 22.3:		<u>POLICIES AND PROCEDURES</u>				
STANDARD <u>22.3.1</u>		<i>Food Services shall be provided in accordance with the policies of the Facility and statutory requirements where applicable. Documented policies and procedures appropriate to the provision of safe and quality food services shall be made accessible to all staff.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
22.3.1.1 CORE	There are written policies and procedures for the Food Services which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorized and dated. There is a mechanism for and evidence of a periodic review at least once in every three years.					
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for the service.				
		2. Policies and procedures are consistent with regulatory requirements and current standard practices.				
		3. Evidence of periodic review of policies and procedures.				
		4. The policies and procedures are endorsed and dated.				
	Facility Comments:					
22.3.1.2	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved. Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.					
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.				
		2. Minutes of meeting with evidence of cross reference with other departments				
		3. Documented cross departmental policies				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
22.3.1.3	Current policies and procedures are communicated to all staff.							
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings						
		2. Circulation list and acknowledgement						
		Facility Comments:						
22.3.1.4 CORE	There is evidence of compliance with policies and procedures.							
	EVIDENCE OF COMPLIANCE	1. Compliance with policies and procedures through:						
		a) interview of staff on practices;						
		b) verify with observation on practices;						
		c) results of audit on practices;						
		d) practices in line with established policies and procedures						
	Facility Comments:							
22.3.1.5	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.							
	EVIDENCE OF COMPLIANCE	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.						
		2. Copy of guidelines on current “Hospital Catering” by Ministry of Health or other recognised bodies is available for reference.						
		Facility Comments:						
22.3.1.6	Fire precautions, disaster plans and safety procedures shall be documented and followed.							

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Manuals/Protocols on safety include:			
		a) Internal fire drill			
		b) Disaster plan			
		c) Evacuation plan			
		d) Safety procedures in the kitchen			
	Facility Comments:				
22.3.1.7	EVIDENCE OF COMPLIANCE	1. Stock control card			
		2. Stock taking records (monthly or quarterly)			
	Facility Comments:				
22.3.1.8	EVIDENCE OF COMPLIANCE	1. Standard operating procedures for storage and handling of food			
		2. Standard operating procedures for monitoring of temperatures			
		3. Cleaning schedule for storage facilities.			
	Facility Comments:				
22.3.1.9	EVIDENCE OF COMPLIANCE	1. Policies and procedures on handling cooked and raw food			
		2. Compliance to procedures as evidenced by work process			
		3. Designated storage and handling areas			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
22.3.1.10	Bulk preparation of food for long term holding such as freezing shall be carried out only if trained staff are available to establish the standards and supervise the handling, preparation, and processing of food stuff.					
	EVIDENCE OF COMPLIANCE	1. Staff training records on bulk preparation and holding				
		2. Standard operating procedures for bulk preparation				
		3. Compliance to procedures as evidenced by work process				
	Facility Comments:					
22.3.1.11	Menus shall be planned to provide meals that meet the needs of patients, selected clients and staff on normal and therapeutic diets. Menus shall also provide for the needs of staff and suit religious and cultural preferences.					
	EVIDENCE OF COMPLIANCE	1. Policies and standard operating procedures for food preparation				
		2. Standard Recipes Book/Cycle/Choice Menus, e.g. vegetarian				
		3. Compliance to procedures as evidence by records				
		4. GMP certification				
		5. HACCP certification				
		6. HALAL certification				
	Facility Comments:					
22.3.1.12	There shall be designated staff to deliver and serve the food to the patients supervised and monitored by the nursing staff.					
	EVIDENCE OF COMPLIANCE	1. Cross departmental policy				
		2. Compliance to policy as evidenced by work process				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
22.3.1.13	There is an appropriate documented procedure to ensure safe provision of meals to infectious patients.					
	EVIDENCE OF COMPLIANCE	1. Documented policy on safe provision of meals for infectious patients.				
		2. Evidence of compliance upon onsite inspection				
	Facility Comments:					
22.3.1.14	Documented procedures shall be evident for the cleaning of all equipment.					
	EVIDENCE OF COMPLIANCE	1. Documented policy and procedures for cleaning of all equipment				
		2. Records on cleaning of equipment				
	Facility Comments:					
22.3.1.15	Procedures for machine and hand dishwashing shall be documented and available.					
	EVIDENCE OF COMPLIANCE	1. Documented policy and procedures for machine and hand washing.				
		2. Compliance to procedures for machine and hand washing as evidenced upon on site inspection.				
	Facility Comments:					
22.3.1.16	Garbage shall be held in covered containers and removed from the Food Services area daily as per schedule.					
	EVIDENCE OF COMPLIANCE	1. Documented policy on waste disposal				
		2. Compliance with the policy on waste disposal.				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	Facility Comments:				
22.3.1.17	There is a proper procedure for the disposal of food refuse.				
	EVIDENCE OF COMPLIANCE	1. Documented policy and procedures for disposal of food refuse.			
		2. Compliance with policy and procedures for disposal of food refuse.			
	Facility Comments:				
22.3.1.18	There is a continuing programme on pest and vermin control.				
	EVIDENCE OF COMPLIANCE	1. Policy and procedures on pest and vermin control			
		2. Inspection and treatment records on pest and vermin control			
	Facility Comments:				
22.3.1.19 CORE	There is evidence of inspection and certification by the Health Authority at least annually and the rating should be 75% and above.				
	EVIDENCE OF COMPLIANCE	1. Certificate by Health Authority			
		2. Monitoring records			
	Facility Comments:				
22.3.1.20	All food services staff shall comply with good hygienic and safety practices including personal hygiene and clothing while on duty.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Policy and procedures on appropriate clothing of staff/food handlers				
		2. Compliance to policies and procedures on hand washing technique				
		3. Representation of the Food Services in Hospital Infection and Antibiotic Control Committee/Team				
	Facility Comments:					
22.3.1.21	The Head of Food Services shall ensure that no staff with the following conditions shall work in any area of food preparation and services during the duration of the illness: a) infected with or who is a carrier of a communicable disease; b) having boils; c) with open or infected skin lesions; d) with an acute respiratory infection.					
	EVIDENCE OF COMPLIANCE	1. Policy on prohibition of staff with specific illness/conditions working in food preparation and services areas include but not limited to items (a) to (d).				
		2. Work instructions for staff to comply during illnesses/conditions				
	Facility Comments:					

SURVEY ITEM &SELF-ASSESSMENT					
TOPIC 22.4:		<u>FACILITIES AND EQUIPMENT</u>			
STANDARD 22.4.1		<i>Appropriate and adequate physical layout, mechanical, electrical facilities, and equipment shall be available for the efficient operations of the Food Services.</i>			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
22.4.1.2	Floors, walls, and ceilings finishes shall be easily cleaned, non-skid, impervious and kept in good repair.					
	EVIDENCE OF COMPLIANCE	1. Floors, walls and ceilings comply with standard materials and kept in good repair as evidenced upon inspection.				
		2. Regular cleaning and maintenance reports				
	Facility Comments:					
22.4.1.3	Lighting shall be adequate and appropriate to provide safe work environment.					
	EVIDENCE OF COMPLIANCE	1. Adequate lighting; electrical lightings are covered.				
		2. Report on regular inspection of lightings				
		3. Maintenance report				
	Facility Comments:					
22.4.1.4	Appropriate ventilation, temperature and humidity control shall be available to provide comfortable working condition and promote cleanliness.					
	EVIDENCE OF COMPLIANCE	1. Temperature and humidity monitoring records,				
		2. Kitchen hood /air extractor maintenance reports				
		3. Comfortable working condition as evidenced upon onsite inspection				
	Facility Comments:					
22.4.1.5	There is evidence of compliance with fire safety requirements.					
	EVIDENCE OF COMPLIANCE	1. Appropriate fire suppression system				
		2. Evacuation plan				
		3. Fire safety inspection records				
		4. Maintenance report				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		5. Reports on fire drill				
		6. Extension of Public Address (PA) system to the kitchen				
	Facility Comments:					
22.4.1.6	Food storage in dry stores, refrigerated stores, and freezers shall comply with appropriate health regulations and standards of good storage practice.					
	EVIDENCE OF COMPLIANCE	1. Temperature monitoring records and trending				
		2. Standard operating procedures on types of food storage facilities				
		3. Storage practices comply with relevant standards				
	Facility Comments:					
22.4.1.7	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.					
	EVIDENCE OF COMPLIANCE	1. Testing, commissioning and calibration records (certificates or stickers)				
		2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as evidence of compliance to the relevant standards and Acts.				
	Facility Comments:					
22.4.1.8 CORE	There is evidence that the facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.					
	EVIDENCE OF COMPLIANCE	1. Planned Preventive Maintenance records (schedule, stickers) including calibration and grease trap inspection records				
		2. Planned Replacement Programme where applicable				
		3. Complaint records				
		4. Asset inventory				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
22.4.1.9	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.					
	EVIDENCE OF COMPLIANCE	1. User training records				
		2. Competency assessment record				
		3. Letter of authorisation				
		4. List of staff trained and authorised to operate specialised equipment				
	Facility Comments:					

SURVEY ITEM &SELF-ASSESSMENT								
TOPIC 22.5: SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES								
STANDARD 22.5.1 <i>The Head of Food Services shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities in Food Services.</i>								
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS				
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING			
22.5.1.1 CORE	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Food Services. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.							
	EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to (f).						
		2. Records on performance improvement activities.						
		3. Minutes of performance improvement meetings						
		4. Quality improvement studies						
		5. Records on innovation if available						
	Facility Comments:							
22.5.1.2	The Head of Food Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement to appropriate individual/personnel within the respective services.							
	EVIDENCE OF COMPLIANCE	1. Minutes of meetings						
		2. Letter of assignment of responsibilities						
		3. Job description						
	Facility Comments:							

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
22.5.1.3	The Head of the Food Services shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility.				
	Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.				
	EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:			
		a) Training of staff			
		b) Policy on incident reporting			
		c) Methodology of incident reporting			
		d) Register/records of incidents			
		2. Completed incident reports			
		3. Root Cause Analysis			
		4. Corrective and preventive action plans			
		5. Remedial measure			
	6. Minutes of meetings				
	7. Acknowledgment by Head of Service and PIC/Hospital Director				
8. Feedback given to staff regarding incident reporting.					
Facility Comments:					
22.5.1.4 CORE	There is tracking and trending of specific performance indicators not limited to but at least two (2) of the following:				
	a) percentage of ready to serve food tested negative for pathogenic microorganism as per schedule (Target: 100%)				
	b) occurrence of physical contamination of food served to patients (Target: sentinel event)				
	c) client food satisfaction survey (Target: above 85%)				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored.				
		2. Records on tracking and trending analysis.				
		3. Remedial measures taken where appropriate				
	Facility Comments:					
22.5.1.5	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.					
	EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff.				
		2. Evidence of feedback via communication on results of performance improvement activities through continuing education activities/meetings.				
		3. Minutes of service/unit/committee meetings				
	Facility Comments:					
22.5.1.6	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.					
	EVIDENCE OF COMPLIANCE	1. Documentation on performance improvement activities and performance indicators.				
		2. Policy statement on anonymity on patients and providers involved in performance improvement activities.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT				
TOPIC 22.6:	<u>SPECIAL REQUIREMENTS</u>			
STANDARD 22.6.1	<u>CAFETERIA SERVICES/FOOD COURT/FOOD OUTLETS/VENDING MACHINES</u> <i>Cafeteria Services/Food Court/Food Outlets/ Vending Machines shall be appropriately staffed, organised and managed to provide safe food for staff and public, in accordance with the overall goals and objectives of the Food Services.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
22.6.1.1 CORE	There shall be a formal contract agreement between the Facility management and Cafeteria Services/Food Court/Food Outlets/Vending Machines operator (if outsourced) stating the requirements of the services.			
	EVIDENCE OF COMPLIANCE	1. Food Service contract include subcontractor contract, where applicable.		
		2. The service contract includes:		
		a) the requirements for provision of safe and quality food as per MSQH Accreditation Standards for Food Services;		
		b) specific requirements;		
		c) Key Performance Indicators.		
		d) Certification ie Kafetaria Sihat / BESS		
	Facility Comments:			
22.6.1.2	Service provider has a valid licence(s) from the relevant local authority to operate the Cafeteria Services/Food Court/Food Outlets/Vending Machines. All food handlers must undergo medical examination and immunisation as well as Food Handlers Training required by relevant statutory requirements. Where the food is prepared off-site, the supplier shall register with the hospital and where appropriate have a valid licence.			
	EVIDENCE OF COMPLIANCE	1. Valid licence from local authority		
		2. Immunisation record (Typhoid)		
		3. Food Handlers Training Certificate		

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	Facility Comments:				
22.6.1.3	The Head of the Food Services shall oversee the operations of the Cafeteria Services/Food Court/Food Outlets/Vending Machines.				
	EVIDENCE OF COMPLIANCE	1. Letter of Appointment of Head of Food Services as overseer of operations of cafeteria/food court/food outlets/Vending Machines.			
		2. Minutes of meeting			
		3. Monitoring schedule and reports			
	Facility Comments:				
22.6.1.4	Sufficient numbers of trained personnel and support staff are employed to allow for the services to meet its documented purposes.				
	EVIDENCE OF COMPLIANCE	1. List of employee			
		2. Duty roster			
		3. Staff training certificate			
	Facility Comments:				
22.6.1.5	There is a structured orientation programme where new staff are briefed on their services, operational policies and relevant aspects to prepare them for their roles and responsibilities.				
	EVIDENCE OF COMPLIANCE	1. Orientation programme schedule and contents			
		2. Attendance list			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
22.6.1.6	There is clear evidence of appropriate quality assurance mechanism and adherence to standards and regulations on Food Quality as stipulated by the local authority, including microbiological testing on food samples.			
	EVIDENCE OF COMPLIANCE			
	1. Records and results of food sampling and inspection			
	2. Food sampling schedule			
	Facility Comments:			
22.6.1.7	There is a process to ensure that no staff with the following conditions shall work in any area of food preparation and services during the duration of the illness:			
	a) infected with or who is a carrier of a communicable disease;			
	b) having boils;			
	c) with open or infected skin lesions;			
	d) with an acute respiratory infection.			
	EVIDENCE OF COMPLIANCE			
	1. Instructions on prohibition of staff with specific illness/conditions working in food preparation and services areas include but not limited to items (a) to (d).			
	2. Monitoring records			
	3. Deployment records			
	Facility Comments:			

SURVEY ITEM & SELF-ASSESSMENT						
STANDARD 22.6.1.1	The Cafeteria Services/Food Court/Food Outlets/Vending Machines shall make available the delivery of safe and quality food services for the staff and public.					
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
22.6.1.1.1	There are written policies and procedures for Cafeteria Services/Food Court/Food Outlets/Vending Machines (in outsourced services terms of contract) that are consistent with the overall policies of the Facility.					
	EVIDENCE OF COMPLIANCE	1. Written policies and procedures for cafeteria services/food court/food outlets/Vending Machines				
	Facility Comments:					
22.6.1.1.2	New and revised policies and procedures are communicated to members of Cafeteria Services/Food Court/Food Outlets management.					
	EVIDENCE OF COMPLIANCE	1. Circulation list and acknowledgement on policies and procedures				
		2. Briefing and attendance records				
		3. Minutes of meetings				
	Facility Comments:					
22.6.1.1.3	There is evidence of compliance with policies and procedures.					
	EVIDENCE OF COMPLIANCE	1. Compliance with policies and procedures through:				
		a) interview of staff on practices;				
		b) verify with observation on practices;				
		c) audit report on compliance with policies and procedures;				
		d) adherence to Good Manufacturing Practice (GMP) guidelines.				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	Facility Comments:				
22.6.1.1.4	Copies of relevant regulations and statutory requirements including guidelines on "Hospital Catering" and current "Garis Panduan Penilaian Pengiktirafan Kafeteria Sihat and Pelaksanaan Mesin Layan Diri/Vending Machine by Ministry of Health or any other recognised bodies are available for reference and are complied with.				
	EVIDENCE OF COMPLIANCE	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.			
		2. Copies of relevant documents including guidelines on "Hospital Catering" by Ministry of Health or other recognised bodies is available for references.			
	Facility Comments:				
22.6.1.1.5	Fire precautions, disaster plans and safety procedures are documented and followed.				
	EVIDENCE OF COMPLIANCE	1. Fire detection and suppression system			
		2. Evacuation plan			
		3. Fire safety inspection records			
		4. Maintenance report			
		5. Reports on Fire drill			
	Facility Comments:				
22.6.1.1.6	Planned preventive and corrective maintenance programmes for equipment and records shall be in place.				
	EVIDENCE OF COMPLIANCE	1. Planned preventive maintenance records			
		2. Corrective maintenance records			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
22.6.1.1.7	Documentation of policies and procedures for storage and handling of food shall be evident.					
	EVIDENCE OF COMPLIANCE	1. Policies and procedures for storage and handling of food				
	Facility Comments:					
22.6.1.1.8	Cooked food and raw food shall be stored and handled separately.					
	EVIDENCE OF COMPLIANCE	1. Cafeteria layout with designated food storage and handling areas				
		2. Compliance to procedures as evidenced by work processes on-site				
	Facility Comments:					
22.6.1.1.9	Garbage shall be held in covered containers and removed from the cafeteria daily as per schedule.					
	EVIDENCE OF COMPLIANCE	1. Policy and procedure on waste disposal				
		2. Garbage disposal schedule				
	Facility Comments:					
22.6.1.1.10	A clear procedure shall be established and documented as regards to the disposal of food refuse.					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Policy and procedures for disposal of food refuse.			
		2. Food refuse disposal schedule			
	Facility Comments:				
22.6.1.1.11	There shall be a continuing programme of pest and vermin control.				
	EVIDENCE OF COMPLIANCE	1. Policy and procedures on pest and vermin control			
		2. Inspection and treatment records on pest and vermin control			
	Facility Comments:				
22.6.1.1.12 CORE	There is evidence of inspection and certification by the Health Authority at least annually and the rating should be 75% and above.				
	EVIDENCE OF COMPLIANCE	1. Certificate by Health Authority			
		2. Monitoring records			
	Facility Comments:				
22.6.1.1.13	Appropriate clean, protective clothing shall be worn by all staff and this clothing shall be changed daily and as required.				
	EVIDENCE OF COMPLIANCE	1. Policy and procedures on appropriate clothing of food handlers evidenced upon onsite inspection			
		2. Records on consumables on Personal Protective Equipment			
		3. Audit record on practice			
	Facility Comments:				
22.6.1.1.14	All food services staff shall comply with good hygienic practices while on duty.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	EVIDENCE OF COMPLIANCE	1. Instructions on handwashing technique at worksite.						
		2. Records on audit on hand washing technique						
	Facility Comments:							

SURVEY ITEM & SELF-ASSESSMENT				
STANDARD 22.6.1.2	To meet its goals and objectives the physical facilities and equipment appropriate to the needs of the Cafeteria Services/Food Court/Food Outlets/Vending Machines shall be available.			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
22.6.1.2.1	The layout areas for Cafeteria Services/Food Court/Food Outlets/Vending Machines shall allow for the following: a) storage of food ensuring adequate separation of dry ration from perishables and adequate separation of perishables by type; b) food handling prior to cooking with separate process areas for meat, fish and vegetables to prevent contamination; c) receiving of food stocks; d) holding of prepared food; e) preparation of food including cooking or reconstitution; f) serving of meals; g) dishwashing and scullery activities; h) storage for crockery and cutlery and other items; i) waste disposal; j) staff rest and changing areas should be outside any food preparation area; k) there shall be separate areas for preparation of salads, pastries, confectionaries; l) adequate hand washing facilities for staff, separate from those utilised for food preparation in the main kitchen area.			
	EVIDENCE OF COMPLIANCE			
	1. Design and layout of the Cafeteria/food court/food outlets/Vending Machines address items (a) to (l)			
	2. Clear signage and labelling of designated areas			
	3. Work process comply with layout plan as evidenced upon on-site inspection			
	Facility Comments:			
22.6.1.2.2	Floors, walls, and ceilings finishes shall be easily cleaned, non-skid, impervious and kept in good repair.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	EVIDENCE OF COMPLIANCE	1. Floors, walls and ceilings comply with standard materials and kept in good repair as evidenced upon inspection					
		2. Regular cleaning and maintenance reports					
	Facility Comments:						
22.6.1.2.3	Appropriate lighting to allow safe work environment shall be available.						
	EVIDENCE OF COMPLIANCE	1. Adequate lighting; electrical lightings are covered.					
		2. Report on regular inspection of lightings					
		3. Electrical lightings should be covered.					
	Facility Comments:						
22.6.1.2.4	Appropriate ventilation, temperature and humidity to provide comfortable working conditions and promote cleanliness.						
	EVIDENCE OF COMPLIANCE	1. Comfortable environment for staff/public as evidenced upon onsite inspection					
		2. Monitoring of temperature records, e.g. Data logger/manual recording					
		3. Maintenance of hood/extractor report					
	Facility Comments:						
22.6.1.2.5	There is evidence that the Cafeteria Services/Food Court/Food Outlets/Vending Machines has complied with fire safety requirements.						
	EVIDENCE OF COMPLIANCE	1. Fire detection and suppression system					
		2. Evacuation plan					
		3. Fire safety inspection records					
		4. Maintenance report					
		5. Reports on fire drill					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	6. Training records				
	Facility Comments:				
22.6.1.2.6	Refrigeration and storage of food in dry storage, refrigerated storage and in freezers shall comply with appropriate health regulations and standards of good practice.				
	EVIDENCE OF COMPLIANCE	1. Temperature monitoring records on freezer/refrigerator and trending			
		2. Compliance to standard operating procedures as evidenced on-site.			
	Facility Comments:				
22.6.1.2.7	There is documented evidence that equipment complies with relevant standards and current statutory requirements.				
	EVIDENCE OF COMPLIANCE	1. Testing, commissioning and calibration records (certificates or stickers)			
		2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as evidence of compliance to the relevant standards and Acts.			
	Facility Comments:				
22.6.1.2.8	There is evidence that the facilities and equipment are maintained in good working order and subject to ongoing planned preventive maintenance and calibration.				
	EVIDENCE OF COMPLIANCE	1. Planned preventive maintenance records			
		2. Calibration records			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
22.6.1.2.9	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.					
	EVIDENCE OF COMPLIANCE	1. User training records				
		2. Competency assessment record				
		3. Letter of authorisation				
		4. List of staff trained and authorised to operate specialised equipment				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT							
STANDARD 22.6.1.3		The Facility management ensures the provision of quality food services in the Cafeteria Services/Food Court/Food Outlets/Vending Machines through ongoing safety and performance improvement activities of the Facility.					
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
22.6.1.3.1	The management through the Head of Food Services shall be responsible for safety and performance improvement activities within the Cafeteria Services/Food Court/Food Outlets/Vending Machines.						
	There is a mechanism on handling of food safety related complaints and corrective actions taken.						
	EVIDENCE OF COMPLIANCE	1. Records on complaints and feedback					
		2. Records on safety and performance improvement activities i.e. food safety initiatives, menu improvements, etc.					
	Facility Comments:						
22.6.1.3.2	Appropriate documentation of safety and performance improvement activities is kept, e.g. client satisfaction survey.						
	EVIDENCE OF COMPLIANCE	1. Records on client food satisfaction survey					
	Facility Comments:						

SURVEYOR SUMMARY:

OVERALL RISK:

SURVEY ITEM & SELF-ASSESSMENT							
SERVICE STANDARD 23 : FORENSIC MEDICINE SERVICES							
	<u>PREAMBLE</u> <i>Forensic Medicine Services standards can be applied when there is a resident Forensic Medicine Specialist in the Facility. These services cover forensic pathology, clinical forensic medicine, medicolegal consultation and forensic laboratory services (if applicable). These services may be provided from within, or external to the Facility by the resident Forensic Medicine Specialist. If the Facility does not provide Forensic Medicine Services, the Standard 23A shall be used for Mortuary Services.</i>						
<u>TOPIC 23.1:</u>	<u>ORGANISATION AND MANAGEMENT</u>						
<u>STANDARD 23.1.1</u>	<i>Where Forensic Medicine Services are provided on site, the services are organised and administered to provide quality Forensic Medicine Services appropriate to the level of medicolegal services provided by the Facility.</i>						
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
23.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Forensic Medicine Services are clearly documented and measurable that indicates safety and quality services been delivered. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.						
	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.					
		2. Goals and objectives of the Forensic Medicine Services in line with the Facility statements are available, endorsed and dated.					
		3. Evidence of planned reviews of the above statements.					
		4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)					

	5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.				
	Facility Comments:				
23.1.1.2 CORE	There is an organisation chart which: a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head of the Forensic Medicine Services, consultants, medical practitioners and staff of the Forensic Medicine Services; b) is accessible to all staff and clients; c) includes off-site services if applicable; d) is revised when there is a major change in any of the following: i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns.				
	EVIDENCE OF COMPLIANCE	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head of the Forensic Medicine Services, consultants, medical practitioners and staff of the Forensic Medicine Services.			
		2. Organisation chart of the service is endorsed, dated and accessible.			
		3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).			
	Facility Comments:				
23.1.1.3	The Forensic Medicine Services are organised to reflect the role of the Facility on the activities of the services, which are readily available and include the following: a) perform professional activities in accordance with the ethical standards of the profession; b) access to information (if applicable) regarding sequence of events, laboratory investigation results, professional consultancy and opinion; c) provision of reasonable quality care by periodic review and evaluation of forensic practice within the Facility;				

	d) communication with medical, nursing, police, and other relevant agencies on matters related to the services provided; e) provision of services on a 24-hour basis; f) provision of consultation services by a Forensic Medicine Specialist to the medical profession and other relevant agencies; g) introduction of new methods, improvement on techniques and participation in research activities, where appropriate.			
	EVIDENCE OF COMPLIANCE 1. Written documentation on the scope of the Forensic Medicine Services to include but not limited to (a) to (g).			
	Facility Comments:			
23.1.1.4	Regular staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Forensic Medicine Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.			
	EVIDENCE OF COMPLIANCE 1. Minutes are accessible, disseminated and acknowledged by the staff.			
	2. Attendance list of members with adequate representatives of the service.			
	3. Frequency of meetings as scheduled.			
	4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).			
	Facility Comments:			
23.1.1.5	The Head of Forensic Medicine Services is involved in the planning, justification and management of the budget and resource utilisation of the services.			
	EVIDENCE OF COMPLIANCE 1. Minutes of Facility-wide management meeting			
	2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service.			
	3. Approved budget and resources.			
	Facility Comments:			

23.1.1.6	The Head of Forensic Medicine Services is involved in the appointment and/OR assignment of staff.					
	EVIDENCE OF COMPLIANCE	1. Records on staff interview (if applicable)				
		2. Appointment/assignment letter of Head of Service				
		3. Job description of Head of Service				
		4. Records on staff deployment				
		5. Duty roster				
	Facility Comments:					
23.1.1.7	There is collaboration between the staff of Forensic Medicine Services with other relevant agency in matters relating to Forensic Medicine activities.					
	EVIDENCE OF COMPLIANCE	1. Documented evidence of interaction with the relevant agency/services of the Facility. <i>*Examples: scan meeting, under-5, maternal mortality etc.</i>				
	Facility Comments:					
23.1.1.8	Appropriate statistics and records shall be maintained in relation to the provision of Forensic Medicine Services and used for managing the services.					
	EVIDENCE OF COMPLIANCE	1. Records are available but not limited to the following:				
		a) workload/census;				
		b) annual report;				
		c) accident/incident reports;				
		d) staffing number and staff profile;				
		e) staff training records;				
		f) data on performance improvement activities, including performance indicators.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT				
STANDARD 23.1.2	<i>Facilities that do not have their own forensic laboratories or cannot provide a full range of forensic laboratory services, shall have arrangements with off-site facilities to provide the services needed.</i> <i>All medico-legal specimens are sent to laboratories as per Criminal Procedure Code (CPC) provision, or other medical based laboratories as identified by legal requirements.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
23.1.2.1	The off-site forensic laboratory shall fulfil the legal requirements as follows: a) stipulated by the provision of Criminal Procedure Code or other relevant directives, national policies and guidelines; b) preservation of the chain of evidence.			
	EVIDENCE OF COMPLIANCE			
	1. The external providers of the Forensic Laboratory Services conform to all relevant approved standards.			
	2. There is a Criminal Procedure Code provision with the external service to provide Forensic Laboratory Services:			
	3. The medical-based laboratory services conform to all relevant approved standards.			
	Facility Comments:			
23.1.2.2	The on-site medical-based laboratory shall fulfil the legal requirements as follows: a) stipulated by the provision of Ministry of Health circulars/directives, national policies and guidelines; b) preservation of the chain of evidence.			
	EVIDENCE OF COMPLIANCE			
	1. Verification on-site during survey on compliance to (a) and (b).			
	Facility Comments:			

SURVEY ITEM &SELF-ASSESSMENT						
TOPIC 23.2		<u>HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT</u>				
STANDARD 23.2.1		<i>The Forensic Medicine Services are supervised by a qualified and competent forensic medicine specialist. The day-to-day operations of the services may be delegated to a suitably qualified, trained and experienced staff.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
23.2.1.1	The direction and supervision of the services shall be by a Forensic Medicine Specialist. The Forensic Medicine Specialist is competent in the specialty and actively practicing as evidenced by: a) being on regular duty in the Forensic Medicine Services; b) participating in continuing medical education activities.					
	EVIDENCE OF COMPLIANCE	1. The Forensic Medicine Specialist is registered with the National Specialist Register (NSR).				
		2. Appointment/assignment letter				
		3. Job description				
		4. Documentation of participation in continuing medical education.				
	Facility Comments:					
23.2.1.2 CORE	The Head and staff of the Forensic Medicine Services shall be individuals qualified by education, training and experience to practice forensic medicine to commensurate with the requirements of the various positions.					
	EVIDENCE OF COMPLIANCE	1. All staff of the Forensic Medicine Services shall have a valid professional Annual Practising Certificate (APC) or its equivalent.				
		2. List of staff with post basic certification in various disciplines.				

		3. Experience of staff meets the demand of their positions.				
		4. Assignment according to staff speciality.				
	Facility Comments:					
23.2.1.3	The authority, responsibilities and accountabilities of the Head of Forensic Medicine Services are clearly delineated and documented.					
	EVIDENCE OF COMPLIANCE	1. Appointment/assignment letter for Head of Service.				
		2. Description of duties and responsibilities.				
	Facility Comments:					
23.2.1.4	Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the need of the services.					
	EVIDENCE OF COMPLIANCE	1. Number of staff and qualification should commensurate with workload.				
		2. Staffing pattern				
		3. Duty roster				
		4. Census and statistics				
	Facility Comments:					
23.2.1.5	There are written and dated specific job descriptions for all categories of staff that include: a) qualifications, training, experience and certification required for the position; b) lines of authority; c) accountabilities, functions and responsibilities; d) reviewed when required and when there is a major change in any of the following: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations. e) administrative and clinical functions.					

	EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e).				
		2. Job description includes specialisation skills				
		3. Relevant privileges granted where applicable				
		4. The job description is acknowledged by the staff and signed by the Head of Service and dated.				
	Facility Comments:					
23.2.1.6	Personnel records on training, staff development, leave and others are maintained for every staff. Note: Staff personal record may be kept in Human Resource Department as per Facility policy.					
	EVIDENCE OF COMPLIANCE	1. Staff personal records include:				
		a) staff biodata;				
		b) qualification and experience;				
		c) evidence of current registration;				
		d) training record;				
		e) competency record and privileging;				
		f) leave record;				
		g) confidentiality agreement;				
		h) health records;				
		i) immunisation status.				
	Facility Comments:					
23.2.1.7	There is a structured orientation programme to introduce new staff to the Forensic Medicine Services and relevant aspects of the Facility to prepare them for their roles and responsibilities. These include but not limited to: a) rules and regulations, especially those related to health hazards and safety precautions; b) all relevant current manuals on operation policies and hazards and safety precautions; c) requirement for immunisation against relevant high-risk diseases (cross reference with the hospital infection control unit).					

	EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme.				
		2. Documentation of orientation and induction programme with relevant topics which include (a) to (c).				
		3. Attendance list.				
	Facility Comments:					
23.2.1.8	Staff are closely supervised and given appropriate instructions to carry out their duties.					
	EVIDENCE OF COMPLIANCE	1. Job description and privileging certificate are available.				
23.2.1.9	Facility Comments:					
23.2.1.9	There is evidence of training needs assessment and staff development plan which provides the knowledge and skills required for staff to maintain competency in their current positions and future advancement.					
	EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and gaps identified.				
		2. A staff development plan based on training needs assessment is available.				
		3. Training schedule/calendar is in place.				
		4. Training module				
	Facility Comments:					
23.2.1.10	There are continuing education activities for staff including medical practitioners to pursue professional interests and to prepare for current and future changes in practice.					
	EVIDENCE OF COMPLIANCE	1. Training calendar includes in-house/external courses/workshop/conferences				
		2. Contents of training programme				
		3. Training records on continuing education activities are kept and maintained for each staff including training in life support.				

		4. Certificate of attendance / postgraduate / degree/ post basic / training.				
	Facility Comments:					
23.2.1.11	Staff including medical practitioners receive written evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.					
	EVIDENCE OF COMPLIANCE	1. Performance appraisals for staff including medical practitioners are completed upon probationary period and as an annual exercise.				
	Facility Comments:					
23.2.1.12	The roles of the Forensic Medicine Services in training and education include undergraduate, postgraduate and other health professional education, research projects and special studies, as appropriate.					
	EVIDENCE OF COMPLIANCE	1. Records of participation in training and education.				
		2. A copy of Memorandum of Understanding (MOU) in the Hospital				
	Facility Comments:					
23.2.1.13	The Forensic Medicine Services shall provide continuing education activities for other health professional staff and relevant agencies to keep them informed of advances in forensic medicine and related fields.					
	EVIDENCE OF COMPLIANCE	1. Records of participation of other health personnel in forensic services in training and education				
		2. A copy of Memorandum of Understanding (MOU) in the Hospital				
	Facility Comments:					

SURVEY ITEM &SELF-ASSESSMENT						
<u>TOPIC 23.3:</u>		<u>POLICIES AND PROCEDURES</u>				
<u>STANDARD 23.3.1</u>		<i>There are written and dated policies and procedures that reflect current knowledge and principles of forensic medicine. They are consistent with statutory requirements and the objectives of the Forensic Medicine Services. There are documented Standard Operating Procedure Manual available for reference.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
23.3.1.1 CORE	There are written policies and procedures for the Forensic Medicine Services which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated.					
	There is a mechanism for and evidence of a periodic review at least once in every three years.					
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for the service.				
		2. Policies and procedures are consistent with regulatory requirements and current standard practices.				
		3. Evidence of periodic review of policies and procedures.				
		4. The policies and procedures are endorsed and dated.				
Facility Comments:						
23.3.1.2	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved.					
Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.						

	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.				
		2. Minutes of meeting with evidence of cross reference with other departments				
		3. Documented cross departmental policies				
	Facility Comments:					
23.3.1.3	Current policies and procedures are communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings				
		2. Circulation list and acknowledgement				
	Facility Comments:					
23.3.1.4	Copies of policies and procedures including Standard Operating Procedure Manual, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible for staff reference.					
	EVIDENCE OF COMPLIANCE	1. Copies of policies and procedures including Standard Operating Procedure Manual, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.				
	Facility Comments:					
23.3.1.5 CORE	There are policies and procedures relating to all post-mortem examinations including but not limited to:					
	a) persons (police or magistrate) who are authorised to order for a forensic post-mortem examination; b) written orders (e.g. Polis 61 Form) for a medico-legal post-mortem examination; c) identification of body part or the deceased by full name*/identification document number*/identity card*/passport*/police report number/post-mortem number and/or medical record number; d) name, rank and number of the police officer ordering the forensic post-mortem examination; e) retention of records and specimens;					

	f) types of specimens collected at post-mortem which are to be submitted for histopathological, microbiological/virological, toxicological and other relevant investigations.			
	EVIDENCE OF COMPLIANCE 1. Documented policies and procedures including but not limited to items (a) to (f). * not applicable to unknown bodies.			
	Facility Comments:			
23.3.1.6	There are written instructions for the proper handling of the specimens as required by law which include collection, labelling, sealing, packaging, transport of specimens, dispatch/handing over to relevant authority. These instructions are readily accessible to the staff. The preservation of chain of evidence shall be maintained throughout the process of specimen handling.			
	EVIDENCE OF COMPLIANCE 1. Standard operating procedures/work instruction/guidelines on specimen handling			
	2. Specimen dispatch record book			
	3. Specimen handling form			
	Facility Comments:			
23.3.1.7 CORE	Complete records and documentation of body management shall be maintained : a) registration of bodies received; b) records of specimens forwarded to other laboratories; c) all specimens and evidences taken from the deceased or examinee; d) all relevant forensic medicine reports (e.g. post-mortem reports, laboratory results) are filed with the records of the deceased or examinee; e) all movement of records or reports out of the forensic services.			
	EVIDENCE OF COMPLIANCE 1. Complete records and documentation of body management include (a) to (e).			
	Facility Comments:			

23.3.1.8 CORE	There is evidence of compliance with policies and procedures. These include but not limited to: a) preparation of the dead body in the ward before transfer to mortuary; b) tagging of the deceased for proper identification; c) method of transportation to the mortuary; d) record of receiving the deceased in the mortuary; e) viewing of the deceased by relatives; f) procedures for releasing the deceased to the next of kin; g) procedures of burial of unclaimed bodies.					
	EVIDENCE OF COMPLIANCE	1. Compliance with policies and procedures through:				
		a) interview of staff on practices;				
		b) verify with observation on practices;				
		c) results of audit on practices;				
		d) practices in line with established policies and procedures .				
	Facility Comments:					
23.3.1.9 CORE	There are written safety procedures and manuals on hazards and safety precautions specific to the Forensic Medicine Services. All staff shall practice Standard Precautions and Safety Guidelines.					
	EVIDENCE OF COMPLIANCE	1. Safety procedures and manuals on hazards and safety precautions are available.				
		2. Verification on practice in Standard Precautions and Safety Guidelines on-site.				
	Facility Comments:					
23.3.1.10	A Forensic Medicine Services staff shall be assigned as the safety officer to monitor safety of staff in the mortuary and observance of Code of Safe Practice as well as Fire Safety Management.					
	EVIDENCE OF COMPLIANCE	1. Assignment letter of Safety Officer				
		2. Job description				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT				
TOPIC 23.4:	<u>FACILITIES AND EQUIPMENT</u>			
STANDARD 23.4.1	<i>There are adequate facilities and equipment for the safe and efficient provision of Forensic Medicine Services taking into consideration the potentially hazardous circumstances of the Forensic Medicine Services. This shall comply with relevant regulations and requirements of statutory authorities.</i>			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT
				SURVEYOR RATING
23.4.1.1	The mortuary shall be accessible from an outside entrance and following a designated route of the Facility.			
	EVIDENCE OF COMPLIANCE	1. Mortuary is accessible from an outside entrance of the Facility.		
		2. Conveyance of body to the Mortuary is via a designated route and entrance.		
	Facility Comments:			
23.4.1.2	Appropriate transport for transferring bodies to the mortuary that commensurate with the dignity and respect accorded to the deceased.			
	EVIDENCE OF COMPLIANCE	1. Proper covered body trolley and appropriate transport are available to transfer the bodies.		
	Facility Comments:			
23.4.1.3 CORE	There are appropriate areas for reception of bodies and storage which include:			
	a) body receiving area shall be of a suitable size and design to facilitate incoming and outgoing of bodies;			
	b) clean and dirty areas are clearly designated;			

	c) there is sufficient space and refrigeration for storage of bodies with provision for accurate identification of bodies; d) the temperature of the body freezer (2-8°C ± 2) shall be maintained, monitored and documented; e) there are adequate space, facilities and equipment for the administrative, professional, and technical functions of the Forensic Medicine Services.			
	EVIDENCE OF COMPLIANCE 1. Appropriate areas for reception of bodies and storage that address (a) to (e).			
	Facility Comments:			
23.4.1.4	There are appropriate areas for post-mortem suite which include: a) access to the post-mortem room shall be controlled; b) the post-mortem room has adequate space, ventilation, and lighting; and is clean; c) there are adequate facilities for performing post-mortem examination and recording of findings, specimen handling and storage; d) the post-mortem equipment is appropriate and adequate to meet the demands of the services and is properly maintained; e) post-mortem table is of a suitable design with proper facilities for the disposal of effluent into the sewage system to ensure safety; f) there is adequate ventilation with extraction for fumes and odours in the work area where appropriate.			
	EVIDENCE OF COMPLIANCE 1. Appropriate areas for post-mortem suite which include items (a) to (f).			
	Facility Comments:			
23.4.1.5 CORE	There is suitable, adequate and safe provision for air conditioning, lighting, power, water, and drainage in the mortuary appropriate to the scope of services provided which include:			

	a) air conditioning, which shall be efficient to maintain low humidity, constant and comfortable room temperature; b) power supply, which shall be adequate, and there are sufficient power sockets which are suitably located; c) adequate and appropriate lighting.					
	EVIDENCE OF COMPLIANCE	1. Suitable, adequate and safe provision of:				
		a) air conditioning;				
		b) lighting;				
		c) power supply;				
		d) water supply;				
		e) effluent drainage.				
	Facility Comments:					
23.4.1.6	There are designated areas for reception and the handling of decomposed bodies/high risk cases where appropriate.					
	EVIDENCE OF COMPLIANCE	1. Designated areas for reception and the handling of decomposed bodies/high risk cases.				
Facility Comments:						
23.4.1.7	There are designated areas for body cleansing/preparation, body viewing, bereavement, performing religious rites and releasing of bodies.					
	EVIDENCE OF COMPLIANCE	1. Designated areas for:				
		a) body cleansing/preparation;				
		b) body viewing;				
		c) bereavement;				
		d) performing religious rites;				
		e) release of bodies.				
	Facility Comments:					

23.4.1.8	There are staff facilities with changing room, shower, locker facilities, and storage for protective clothing/gear, and they are suitably located.					
	EVIDENCE OF COMPLIANCE	1. Staff facilities are available as follows:				
		a) changing room;				
		b) shower;				
		c) locker facilities;				
		d) storage for protective clothing/gear.				
	Facility Comments:					
23.4.1.9	There are adequate and appropriate data processing, retrieval, and communication facilities.					
	EVIDENCE OF COMPLIANCE	1. Documentation on death registration.				
		2. Communication facilities.				
	Facility Comments:					
23.4.1.10	Where specialised equipment such as autopsy saw and chemicals, e.g.10% formaldehyde and other hazardous chemicals are used, there shall be evidence that only staff who are trained and authorised operate such equipment/chemical.					
	EVIDENCE OF COMPLIANCE	1. User training records				
		2. Competency assessment record*				
		3. List of staff trained and authorised to operate specialised equipment				
		4. Material Safety Data Sheet (MSDS) documents on usage, storage and disposal of hazardous chemicals are available on-site.				
		<i>*Refer to the Credentialing and Privileging Record (Postmortem techniques, evidence management, chain of custody, mortuary management, crime scene etc.)</i>				
	Facility Comments:					

23.4.1.11	All equipment shall meet current safety standards, e.g. electrical safety code based on Testing and Commissioning (T&C) documentation.					
	EVIDENCE OF COMPLIANCE	1. T&C documentation is available for equipment.				
	Facility Comments:					
23.4.1.12	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.					
	EVIDENCE OF COMPLIANCE	1. Testing, commissioning and calibration records (certificates or stickers)				
		2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as evidence of compliance to the relevant standards and Acts.				
	Facility Comments:					
23.4.1.13	Adequate and designated storage area for consumables and chemicals.					
	EVIDENCE OF COMPLIANCE	1. Storage area for consumables and chemicals.				
		2. Inventory list for consumables and chemicals.				
		3. Material Safety Data Sheet (MSDS) documents on usage, storage and disposal of hazardous chemicals are available on-site.				
	Facility Comments:					
23.4.1.14 CORE	Planned preventive maintenance of equipment, instrument and facility are in place.					

	EVIDENCE OF COMPLIANCE	1. Asset inventory				
		2. Complaint records				
		3. Logbook and Planned Preventive Maintenance (PPM) records are available.				
		4. Calibration records are available.				
		5. Replacement of equipment (Beyond Economic Repair) if applicable.				
	Facility Comments:					
23.4.1.15	There is evidence of general cleanliness in the Forensic Medicine Services.					
	EVIDENCE OF COMPLIANCE	1. Good housekeeping is evidenced on-site.				
	Facility Comments:					
23.4.1.16	There are proper facilities for the disposal of biohazard material as either effluent or containerised material.					
	EVIDENCE OF COMPLIANCE	1. Proper disposal of biohazard material as containerised material or effluent according to regulations evidenced on-site.				
	Facility Comments:					

SURVEY ITEM &SELF-ASSESSMENT						
TOPIC 23.5:		<u>SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES</u>				
STANDARD <u>23.5.1</u>		<i>The Head of Forensic Medicine Services shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Forensic Medicine Services.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
23.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Forensic Medicine Services. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.					
	EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to (f)				
		2. Records on performance improvement activities.				
		3. Minutes of performance improvement meetings				
		4. Performance improvement studies				
		5. Records on innovation if available				
	Facility Comments:					
23.5.1.2	The Head of Forensic Medicine Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement to appropriate individual/personnel within the respective services.					

	EVIDENCE OF COMPLIANCE	1. Minutes of meetings				
		2. Letter of assignment of responsibilities				
		3. Job description				
	Facility Comments:					
23.5.1.3	The Head of the Forensic Medicine Services shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility. Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.					
EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:					
	a) Training of staff					
	b) Policy on incident reporting					
	c) Methodology of incident reporting					
	d) Register/records of incidents					
	2. Completed incident reports					
	3. Root Cause Analysis					
	4. Corrective and preventive action plans					
	5. Remedial measure					
	6. Minutes of meetings					
7. Acknowledgment by Head of Service and PIC/Hospital Director						
8. Feedback given to staff regarding incident reporting.						
Facility Comments:						
23.5.1.4 CORE	There is tracking and trending of specific performance indicators not limited to but at least two (2) of the following: a) turnaround time of ≤ 3 hours for releasing bodies (non-police cases) to the next of kin/claimant after body registration. (Target: ≥80%) b) percentage of bodies released to the right next of kin/claimant					

	(Target: ≥99%) – sentinel event needs to be investigated immediately c) percentage of completion of post-mortem reports for non-complicated cases from the date of post-mortem within twelve (12) weeks (Target: ≥80%) Notes/Explanations Non-complicated cases refer to accidents, suicides and natural deaths which are routine police cases subjected to forensic post-mortem examination.										
	<table><tr><td rowspan="3">EVIDENCE OF COMPLIANCE</td><td>1. Specific performance indicators monitored.</td><td></td></tr><tr><td>2. Records on tracking and trending analysis.</td><td></td></tr><tr><td>3. Remedial measures taken where appropriate.</td><td></td></tr></table>	EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored.		2. Records on tracking and trending analysis.		3. Remedial measures taken where appropriate.				
EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored.										
	2. Records on tracking and trending analysis.										
	3. Remedial measures taken where appropriate.										
	Facility Comments:										
23.5.1.5	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.										
	<table><tr><td rowspan="3">EVIDENCE OF COMPLIANCE</td><td>1. Results on safety and performance improvement activities are accessible to staff.</td><td></td></tr><tr><td>2. Evidence of feedback via communication on results of performance improvement activities through continuing education activities/meetings.</td><td></td></tr><tr><td>3. Minutes of service meetings</td><td></td></tr></table>	EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff.		2. Evidence of feedback via communication on results of performance improvement activities through continuing education activities/meetings.		3. Minutes of service meetings				
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	2. Evidence of feedback via communication on results of performance improvement activities through continuing education activities/meetings.										
	3. Minutes of service meetings										
	Facility Comments:										
23.5.1.6	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and deceased is preserved.										
	<table><tr><td rowspan="2">EVIDENCE OF COMPLIANCE</td><td>1. Documentation on performance improvement activities and performance indicators.</td><td></td></tr><tr><td>2. Policy statement on anonymity on deceased and providers involved in performance improvement activities.</td><td></td></tr></table>	EVIDENCE OF COMPLIANCE	1. Documentation on performance improvement activities and performance indicators.		2. Policy statement on anonymity on deceased and providers involved in performance improvement activities.						
EVIDENCE OF COMPLIANCE	1. Documentation on performance improvement activities and performance indicators.										
	2. Policy statement on anonymity on deceased and providers involved in performance improvement activities.										
	Facility Comments:										

23.5.1.7	Forensic Medicine Services with forensic laboratory shall have an internal and external/interlaboratory comparison quality control programme. The results of the internal and external/interlaboratory comparison quality control shall be displayed and readily understood by relevant staff.					
	EVIDENCE OF COMPLIANCE	1. Evidence of participation of Internal Quality Control (IQC) and External Quality Control (EQA)/Interlaboratory Comparison.				
		2. Performance review/discussion of IQC and EQA/ Interlaboratory Comparison.				
	Facility Comments:					
23.5.1.8	Forensic Medicine Specialist shall participate in audit activities with other clinical specialists.					
	EVIDENCE OF COMPLIANCE	1. Records of audit activities.				
		Facility Comments:				

SURVEYOR SUMMARY:

OVERALL RISK:

SURVEY ITEM & SELF-ASSESSMENT			
SERVICE STANDARD 23A : MORTUARY SERVICES			
	<u>PREAMBLE</u> <i>Mortuary Services shall be provided within the Facility. Where there is no resident Forensic Medicine Specialist, the Mortuary Services comes under the purview of the Person In Charge (PIC) of the Facility. The Mortuary Services shall include but are not limited to provision of:</i> a) <i>Body reception</i> b) <i>Body storage</i> c) <i>Body preparation/release area</i> d) <i>Area for body viewing</i> e) <i>Bereavement/counselling room</i> f) <i>Post-mortem suite (where applicable)</i>		
<u>TOPIC 23A.1:</u> <u>STANDARD 23A.1.1</u>	<u>ORGANISATION AND MANAGEMENT</u> <i>The Mortuary Services are organised and administered to provide quality services appropriate to the level of mortuary services provided by the Facility.</i>		
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT
			SURVEYOR RATING
23A.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Mortuary Services are clearly documented and measurable that indicates safety and quality services been delivered. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.		

	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.				
		2. Goals and objectives of the Mortuary Services in line with the Facility statements are available, endorsed and dated.				
		3. Evidence of planned reviews of the above statements.				
		4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)				
		5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.				
	Facility Comments:					
23A.1.1.2 CORE	There is an organisation chart which:					
	a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head of Mortuary Services, medical practitioners and staff of Mortuary Services;					
	b) is accessible to all staff and clients;					
	c) includes off-site services if applicable;					
	d) is revised when there is a major change in any of the following:					
	i) organisation;					
	EVIDENCE OF COMPLIANCE	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head of the Mortuary Services, medical practitioners and staff of the Mortuary Services.				
		2. Organisation chart of the service is endorsed, dated and accessible.				
		3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).				
	Facility Comments:					
23A.1.1.3	The Mortuary Services are organised to reflect the role of the Facility on the activities of the services, which are readily available and include the following:					

	a) perform professional activities in accordance with the ethical standards of the professions; b) provision of reasonable quality care by periodic review and evaluation of forensic practice within the Facility; c) communication with medical, nursing, police, and other relevant agencies on matters related to the services provided; d) provision of services on a 24-hour basis.					
	EVIDENCE OF COMPLIANCE	1. Written documentation for the Mortuary Services include but not limited to items (a) to (d).				
	Facility Comments:					
23A.1.1.4	Regular staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Mortuary Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.					
	EVIDENCE OF COMPLIANCE	1. Minutes are accessible, disseminated and acknowledged by the staff.				
		2. Attendance list of members with adequate representatives of the service.				
		3. Frequency of meetings as scheduled.				
		4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).				
	Facility Comments:					
23A.1.1.5	The Head of Mortuary Services is involved in the planning, justification and management of the budget and resource utilisation of the services.					
	EVIDENCE OF COMPLIANCE	1. Minutes of Facility-wide management meeting				
		2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service.				
		3. Approved budget and resources				
	Facility Comments:					

23A.1.1.6	The Head of Mortuary Services is involved in the appointment and/OR assignment of staff.					
	EVIDENCE OF COMPLIANCE	1. Records on staff interview (if applicable)				
		2. Appointment/assignment letter of Head of Service				
		3. Job description of Head of Service				
		4. Records on staff deployment				
		5. Duty roster				
	Facility Comments:					
23A.1.1.7	There is collaboration between the staff of Mortuary Services with other relevant agencies in matters relating to mortuary activities.					
	EVIDENCE OF COMPLIANCE	1. Documented evidence of interaction with the relevant agencies of the Facility. <i>*Examples: scan meeting, under-5, maternal mortality etc.</i>				
		Facility Comments:				
23A.1.1.8	Appropriate statistics and records shall be maintained in relation to the provision of Mortuary Services and used for managing the services.					
	EVIDENCE OF COMPLIANCE	1.Records are available but not limited to the following:				
		a) workload/census;				
		b) annual report;				
		c) accident/incident reports;				
		d) staffing number and staff profile;				
		e) staff training records;				
	f) data on performance improvement activities, including performance indicators.					
	Facility Comments:					

SURVEY ITEM &SELF-ASSESSMENT					
TOPIC 23A.2	<u>HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT</u>				
STANDARD <u>23A.2.1</u>	<i>The Mortuary Services are supervised by a suitably qualified, trained and competent medical practitioner and assisted by relevant categories of staff.</i>				
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
23A.2.1.1 CORE	The Head and staff of the Mortuary Services shall be individuals qualified by education, training, experience and certification to meet the demands of the various positions and to achieve the objectives of the services. a) The direction and supervision of the services shall be by a medical practitioner/ local facility's head and also supervision by the state head of forensic medicine services. (KIV 2021) – documented sort of approval b) There is evidence that the staff have some training or experience in the processes governing the mortuary.				
	EVIDENCE OF COMPLIANCE	1. Appointment/assignment letter			
		2. Certification			
		3. Training and competency records			
	Facility Comments:				
23A.2.1.2	The authority, responsibilities and accountabilities of the Head of Mortuary Services are clearly delineated and documented.				
	EVIDENCE OF COMPLIANCE	1. Appointment/assignment letter for Head of Service.			
		2. Description of duties and responsibilities.			
	Facility Comments:				

23A.2.1.3	Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the need of the services.					
	EVIDENCE OF COMPLIANCE	1. Number of staff and qualification should commensurate with workload.				
		2. Staffing pattern				
		3. Duty roster				
		4. Census and statistics				
	Facility Comments:					
23A.2.1.4	There are written and dated specific job descriptions for all categories of staff that include: a) qualifications, training, experience and certification required for the position; b) lines of authority; c) accountabilities, functions and responsibilities, d) reviewed when required and when there is a major change in any of the following: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations. e) administrative and clinical functions.					
	EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e).				
		2. Job description includes specialisation skills				
		3. Relevant privileges granted where applicable				
		4. The job description is acknowledged by the staff and signed by the Head of Service and dated.				
	Facility Comments:					
23A.2.1.5	Personnel records on training, staff development, leave and others are maintained for every staff.					

	Note: Staff personal record may be kept in Human Resource Department as per Facility policy.				
	EVIDENCE OF COMPLIANCE	1. Staff personal records include:			
		a) staff biodata;			
		b) qualification and experience;			
		c) evidence of current registration;			
		d) training record;			
		e) competency record and privileging;			
		f) leave record;			
		g) confidentiality agreement;			
		h) health records;			
		i) immunisation status.			
Facility Comments:					
23A.2.1.6	There is a structured orientation programme to introduce new staff to the Mortuary Services and relevant aspects of the Facility to prepare them for their roles and responsibilities. These include but not limited to: a) rules and regulations, especially those related to health hazards and safety precautions; b) all relevant current manuals on operational policies and hazards and safety precautions; c) requirement for immunisation against relevant high-risk diseases (cross reference with the hospital infection control unit).				
EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme.				
	2. Documentation of orientation and induction programme with relevant topics which include items (a) to (c).				
	3. Attendance list				
Facility Comments:					
23A.2.1.7	Staff are closely supervised and given appropriate instruction to carry out their duties.				

	EVIDENCE OF COMPLIANCE	1. Job description				
		2. Privileging certificate				
		3. Competency/supervision records				
	Facility Comments:					
23A.2.1.8	There is evidence of training needs assessment and staff development plan which provides the knowledge and skills required for staff to maintain competency in their current positions and future advancement.					
	EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and gaps identified.				
		2. A staff development plan based on training needs assessment is available.				
		3. Training schedule/calendar is in place.				
		4. Training module				
	Facility Comments:					
23A.2.1.9	There are continuing education activities for staff to pursue professional interests and to prepare for current and future changes in practice.					
	EVIDENCE OF COMPLIANCE	1. Training calendar includes in-house/external courses/workshop/conferences				
		2. Contents of training programme				
		3. Training records on continuing education activities are kept and maintained for each staff including training in life support.				
		4. Certificate of attendance / postgraduate / degree/ post basic / training.				
	Facility Comments:					
23A.2.1.10	Staff including medical practitioners receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.					

	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff including medical practitioners is completed upon probationary period and as an annual exercise.				
	Facility Comments:					
23A.2.1.11	The Mortuary Services (forensic medicine specialist) shall provide continuing education activities for other health professional staff and relevant agencies to keep them informed of advances in forensic related field.					
	EVIDENCE OF COMPLIANCE	1. Records on participation of other health personnel in training and education in Mortuary Services.				
	Facility Comments:					

SURVEY ITEM &SELF-ASSESSMENT						
<u>TOPIC 23A.3</u>		<u>POLICIES AND PROCEDURES</u>				
<u>STANDARD 23A.3.1</u>		<i>There are written and dated policies and procedures that reflect current knowledge and principles of mortuary practice. They are consistent with statutory requirements and the objectives of the Mortuary Services.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
23A.3.1.1 CORE	There are written policies and procedures for the Mortuary Services which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated.					
	There is a mechanism for and evidence of a periodic review at least once in every three years.					
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for the service.				
		2. Policies and procedures are consistent with regulatory requirements and current standard practices.				
		3. Evidence of periodic review of policies and procedures.				
		4. The policies and procedures are endorsed and dated.				
Facility Comments:						
23A.3.1.2	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners and reviewed by the head of state forensic service, Management and where required with other external service providers and with reference to relevant sources involved.					
Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.						

	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.				
		2. Minutes of meeting with evidence of cross reference with other departments				
		3. Documented cross departmental policies				
	Facility Comments:					
23A.3.1.3	Current policies and procedures are communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings				
		2. Circulation list and acknowledgement				
	Facility Comments:					
23A.3.1.4	Copies of policies and procedures including Standard Operating Procedure Manual, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible for staff reference.					
	EVIDENCE OF COMPLIANCE	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.				
	Facility Comments:					
23A.3.1.5	There are policies and procedures relating to all post-mortem examinations:					
	a) persons (police or magistrate) who are authorised to order for a post-mortem examination; b) written orders (e.g. Polis 61 Form) for a medico-legal post-mortem examination; c) identification of body part or the deceased by full name*/identification document number*/identity card*/passport*/police report number/post-mortem number and/or medical record number; d) name, rank and number of the police officer ordering the forensic post-mortem examination; e) retention of records and specimens;					

	f) types of specimens collected at post-mortem which are to be submitted for histopathological, microbiological/virological, toxicological and other relevant investigation. * not applicable to unknown bodies.												
	<table><tr><td>EVIDENCE OF COMPLIANCE</td><td>1. Documented policies and procedures including but not limited to items (a) to (f).</td><td></td></tr></table>	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures including but not limited to items (a) to (f).										
EVIDENCE OF COMPLIANCE	1. Documented policies and procedures including but not limited to items (a) to (f).												
	Facility Comments:												
23A.3.1.6	There are written instructions for the proper handling of the specimens as required by law which include collection, labelling, sealing, packaging, transport of specimens, dispatch/handing over to relevant authority. These instructions are readily accessible to the staff. The preservation of chain of evidence shall be maintained throughout the process of specimen handling.												
	<table><tr><td>EVIDENCE OF COMPLIANCE</td><td>1. Standard operating procedures/work instruction/guidelines on specimen handling</td><td></td></tr><tr><td></td><td>2. Specimen dispatch record book</td><td></td></tr><tr><td></td><td>3. Specimen handling form</td><td></td></tr></table>	EVIDENCE OF COMPLIANCE	1. Standard operating procedures/work instruction/guidelines on specimen handling			2. Specimen dispatch record book			3. Specimen handling form				
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	2. Specimen dispatch record book												
	3. Specimen handling form												
	Facility Comments:												
23A.3.1.7 CORE	Complete records and documentation of body management shall be maintained where applicable: a) registration of bodies received; b) records on specimens forwarded to other laboratories; c) all specimens and evidences taken from the deceased or examinee; d) all relevant forensic medicine reports (e.g. post-mortem reports, laboratory results) are filed with the records on the deceased or examinee; e) all movement of records or reports out of the forensic services.												

	EVIDENCE OF COMPLIANCE	1. Complete records and documentation of body management include (a) to (e).				
	Facility Comments:					
23A.3.1.8 CORE	There is evidence of compliance with policies and procedures. These include but not limited to:					
	a) preparation of the dead body in the ward before transfer to mortuary; b) tagging of the deceased for proper identification; c) method of transportation to the mortuary; d) record of receiving the deceased in the mortuary; e) viewing of the deceased by relatives; f) procedures for releasing the deceased to the next of kin; g) procedures of burial of unclaimed bodies.					
	EVIDENCE OF COMPLIANCE	1. Compliance with policies and procedures through:				
		a) interview of staff on practices;				
		b) verify with observation on practices;				
		c) results of audit on practices;				
		d) practices in line with established policies and procedures.				
	Facility Comments:					
23A.3.1.9	There are written safety procedures and manuals on hazards and safety precautions specific to the Mortuary Services. All staff shall practice Standard Precautions and Safety Guidelines.					
	EVIDENCE OF COMPLIANCE	1. Safety procedures and manuals on hazards and safety precautions are available.				
		2. Verification on practice on compliance to Standard Precautions and Safety Guidelines on-site.				
	Facility Comments:					

23A.3.1.10	A Mortuary Services staff shall be assigned as the safety officer to monitor safety in the mortuary and observance of Code of Safe Practice.					
	EVIDENCE OF COMPLIANCE	1. Assignment letter of Safety Officer				
		2. Job description				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT							
TOPIC 23A.4:		<u>FACILITIES AND EQUIPMENT</u>					
STANDARD <u>23A.4.1</u>		<i>There are adequate facilities and equipment for the safe and efficient provision of Mortuary Services taking into consideration the scope of services and potentially hazardous circumstances of the Mortuary Services. This shall comply with relevant regulations and statutory requirements.</i>					
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
23A.4.1.1	The mortuary shall be accessible from an outside entrance and following a designated route of the Facility.						
	EVIDENCE OF COMPLIANCE	1. Mortuary is accessible from an outside entrance of the Facility.					
		2. Conveyance of body to the Mortuary is via a designated route and entrance.					
	Facility Comments:						
23A.4.1.2	Appropriate transport for transferring bodies to the mortuary that commensurate with the dignity and respect accorded to the deceased.						
	EVIDENCE OF COMPLIANCE	1. Proper covered body trolley and appropriate transport are available to transfer the bodies.					
	Facility Comments:						
23A.4.1.3	There are appropriate areas for reception of bodies and storage where applicable.						
	a) body receiving area shall be of a suitable size and design to facilitate incoming and outgoing of bodies; b) clean and dirty areas are clearly designated;						

	c) there is sufficient space and refrigeration for storage of bodies with provision for accurate identification of bodies; d) the temperature of the body freezer (2-8°C ± 2) shall be maintained, monitored and documented; e) there are adequate space, facilities and equipment for the administrative, professional, and technical functions of the Mortuary Services.			
	EVIDENCE OF COMPLIANCE 1. Appropriate areas for reception of bodies and storage that address items (a) to (e).			
	Facility Comments:			
23A.4.1.4	There are appropriate areas for post-mortem suite (where applicable), which include: a) access to the post-mortem room shall be controlled; b) the post-mortem room is clean and has adequate space, ventilation and lighting; c) there are adequate facilities for performing post-mortem examination, recording of findings, specimen handling and storage; d) the post-mortem equipment is appropriate, adequate and is properly maintained; e) post-mortem table is of a suitable design with proper facilities for the disposal of effluent into the sewage system to ensure safety; f) there is adequate ventilation with extraction for fumes and odours in the work area where appropriate.			
	EVIDENCE OF COMPLIANCE 1. Appropriate areas for post-mortem suite which include (a) to (f).			
	Facility Comments:			
23A.4.1.5	There is suitable, adequate and safe provision for air conditioning, lighting, power, water, and drainage, appropriate to the scope of services provided which include: a) air conditioning, which shall be efficient to maintain low humidity, constant and comfortable room temperature.			

	b) power supply, which shall be adequate, and there are sufficient power sockets which are suitably located. c) adequate and appropriate lighting.																
	<table><tr><td rowspan="6">EVIDENCE OF COMPLIANCE</td><td colspan="2">1. Suitable, adequate and safe provision of:</td></tr><tr><td>a) air conditioning;</td><td></td></tr><tr><td>b) lighting;</td><td></td></tr><tr><td>c) power supply;</td><td></td></tr><tr><td>d) water supply,</td><td></td></tr><tr><td>e) effluent drainage.</td><td></td></tr></table> Facility Comments:	EVIDENCE OF COMPLIANCE	1. Suitable, adequate and safe provision of:		a) air conditioning;		b) lighting;		c) power supply;		d) water supply,		e) effluent drainage.				
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	a) air conditioning;																
	b) lighting;																
	c) power supply;																
	d) water supply,																
	e) effluent drainage.																
23A.4.1.6	There are designated areas for reception and the handling of decomposed bodies/high risk cases where appropriate.																
	<table><tr><td rowspan="2">EVIDENCE OF COMPLIANCE</td><td colspan="2">1. Designated areas for reception and the handling of decomposed bodies/high risk cases.</td></tr><tr><td></td><td></td></tr></table> Facility Comments:	EVIDENCE OF COMPLIANCE	1. Designated areas for reception and the handling of decomposed bodies/high risk cases.														
EVIDENCE OF COMPLIANCE	1. Designated areas for reception and the handling of decomposed bodies/high risk cases.																
23A.4.1.7	There are designated areas for body cleansing/preparation, body viewing, bereavement, performing religious rites and release of bodies.																
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EVIDENCE OF COMPLIANCE	1. Designated areas for:																
	a) body cleansing/preparation,																
	b) body viewing,																
	c) bereavement,																
	d) performing religious rites;																
	e) release of bodies.																
23A.4.1.8	Where appropriate, there are staff facilities with changing room, shower, locker facilities, and storage for protective clothing/gear and they are suitably located.																

	EVIDENCE OF COMPLIANCE	1. Staff facilities are available as follows:				
		a) changing room;				
		b) shower;				
		c) locker facilities;				
		d) storage for protective clothing/gear.				
	Facility Comments:					
23A.4.1.9	There are adequate and appropriate data processing, retrieval, and communication facilities.					
	EVIDENCE OF COMPLIANCE	1. Documentation on death registration;				
		2. Communication facilities.				
	Facility Comments:					
23A.4.1.10	Where specialised equipment such as autopsy saw and chemicals, e.g. 10% formaldehyde and other hazardous chemicals are used, there is evidence that only staff who are trained and authorised operate such equipment/chemicals.					
	EVIDENCE OF COMPLIANCE	1. User training records				
		2. Competency assessment record*				
		3. List of staff trained and authorised to operate specialised equipment				
		4. Material Safety Data Sheet (MSDS) documents on usage, storage and disposal of hazardous chemicals are available on-site.				
		*Refer to the Credentialing and Privileging Record (Postmortem techniques, evidence management, chain of custody, mortuary management, crime scene etc.)				
Facility Comments:						
23A.4.1.11	All equipment shall meet current safety standards, e.g. electrical safety code based on Testing & Commissioning (T&C) documentation.					

	EVIDENCE OF COMPLIANCE	1. T&C documentation is available for equipment.				
	Facility Comments:					
23A.4.1.12	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.					
	EVIDENCE OF COMPLIANCE	1. Testing, commissioning and calibration records (certificates or stickers)				
		2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as evidence of compliance to the relevant standards and Acts.				
	Facility Comments:					
23A.4.1.13	Adequate and designated storage area for consumables and chemicals.					
	EVIDENCE OF COMPLIANCE	1. Storage area for consumables and chemicals.				
		2. Inventory list for consumables and chemicals.				
	Facility Comments:					
23A.4.1.14 CORE	Where applicable, planned preventive maintenance of equipment, instrument and facility are in place.					
	EVIDENCE OF COMPLIANCE	1. Asset inventory				
		2. Complaint records				
		3. Logbook and Planned Preventive Maintenance (PPM) records are available.				
		4. Calibration records are available.				
		5. Replacement of equipment (Beyond Economic Repair) if applicable.				
	Facility Comments:					

23A.4.1.15	There is evidence of general cleanliness in the Mortuary Services.					
	EVIDENCE OF COMPLIANCE	1. Good housekeeping is evidenced.				
	Facility Comments:					
23A.4.1.16	There are proper facilities for the disposal of biohazard material as either effluent or containerised material.					
	EVIDENCE OF COMPLIANCE	1. Proper disposal of biohazard material as containerised material or effluent according to regulations evidenced on-site.				
		2. Material Safety Data Sheet (MSDS) documents on usage, storage and disposal of hazardous chemicals are available on-site.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 23A.5:		<u>SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES</u>				
STANDARD <u>23A.5.1</u>		<i>The Head of Mortuary Services shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Mortuary Services.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
23A.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Mortuary Services. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.					
	EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to (f).				
		2. Records on performance improvement activities.				
		3. Minutes of performance improvement meetings				
		4. Performance improvement studies				
		5. Records on innovation if available				
	Facility Comments:					
23A.5.1.2	The Head of Mortuary Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement to appropriate individual/personnel within the respective services.					

	EVIDENCE OF COMPLIANCE	1. Minutes of meetings					
		2. Letter of assignment of responsibilities					
		3. Job description					
	Facility Comments:						
23A.5.1.3	The Head of the Mortuary Services shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility.						
	Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.						
	EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:					
		a) Training of staff					
		b) Policy on incident reporting					
		c) Methodology of incident reporting					
		d) Register/records of incidents					
		2. Completed incident reports					
		3. Root Cause Analysis					
		4. Corrective and preventive action plans					
		5. Remedial measure					
		6. Minutes of meetings					
		7. Acknowledgment by Head of Service and PIC/Hospital Director					
		8. Feedback given to staff regarding incident reporting.					
Facility Comments:							
23A.5.1.4 CORE	There is tracking and trending of specific performance indicators not limited to but at least two (2) of the following:						
	a) turnaround time of ≤ 3 hours for releasing bodies (non-police cases) to the next of kin/claimant after body registration. (Target: ≥80%)						

	b) percentage of bodies released to the right next of kin/claimant (Target: ≥99%) – sentinel event need to be investigated immediately c) percentage of completion of post-mortem reports for non-complicated cases from the date of post-mortem within twelve (12) weeks (Target: ≥80%) Notes/Explanations Non-complicated cases refer to accidents, suicide and natural deaths which are routine police cases subjected to forensic post-mortem examination.			
	EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored.		
		2. Records on tracking and trending analysis.		
		3. Remedial measures taken where appropriate.		
	Facility Comments:			
23A.5.1.5	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.			
	EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff.		
		2. Evidence of feedback via communication on results of performance improvement activities through continuing education activities/meetings.		
		3. Minutes of service/unit meetings		
	Facility Comments:			
23A.5.1.6	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and deceased is preserved.			
	EVIDENCE OF COMPLIANCE	1. Documentation on performance improvement activities and performance indicators.		
		2. Policy statement on anonymity on deceased and providers involved in performance improvement activities.		
	Facility Comments:			

23A.5.1.7	Mortuary staff shall participate in audit activities with other clinical specialists.				
	EVIDENCE OF COMPLIANCE	1. Records on audit activities.			
	Facility Comments:				

SERVICE SUMMARY	
SURVEYOR SUMMARY:	
OVERALL RATING:	
OVERALL RISK:	

SURVEY ITEM & SELF-ASSESSMENT					
SERVICE STANDARD 24 : STANDARDS FOR GENERAL APPLICATION					
	PREAMBLE <i>This chapter contains general criteria for the assessment or review of specific functions or services which are an integral part of the organisational structure of the Facility and for which a specific set of standards are not yet developed. Some of these services or units may need to have additional criteria developed which are particular to them and applied within reason depending on range and scope of services provided.</i>				
TOPIC 24.1: STANDARD 24.1.1	ORGANISATION AND MANAGEMENT <i>The Service is organised and administered to provide optimum care for patients according to the goals and objectives of the Facility and to meet the needs of the patient population being served.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
24.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Service are clearly documented and measurable. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.				
	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.			
		2. Goals and objectives of the Service in line with the Facility statements are available, endorsed and dated.			
		3. Evidence of planned reviews of the above statements.			
		4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)			
		5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.			
	Facility Comments:				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
24.1.1.2 CORE	There is an organisation chart which: a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head and staff of the Service; b) is accessible to all staff and clients; c) includes off-site services if applicable; d) is revised when there is a major change in any of the following: i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns.			
	EVIDENCE OF COMPLIANCE			
	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head and staff of the Service.			
	2. Organisation chart of the service is endorsed, dated and accessible.			
	3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).			
	Facility Comments:			
24.1.1.3	Regular staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Service. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.			
	EVIDENCE OF COMPLIANCE			
	1. Minutes are accessible, disseminated and acknowledged by the staff.			
	2. Attendance list of members with adequate representatives of the service.			
	3. Frequency of meetings as scheduled.			
	4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).			
	Facility Comments:			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
24.1.1.4	The Head of Service is involved in the planning, justification and management of the budget and resource utilisation of the services.					
	EVIDENCE OF COMPLIANCE	1. Minutes of Facility-wide management meeting				
		2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service.				
		3. Approved budget and resources.				
	Facility Comments:					
24.1.1.5	The Head of Service is involved in the appointment and/OR assignment of staff.					
	EVIDENCE OF COMPLIANCE	1. Records on staff interview				
		2. Appointment/assignment letter of Head of Service				
		3. Job description of Head of Service				
		4. Records on staff deployment				
		5. Duty roster				
	Facility Comments:					
24.1.1.6	Appropriate statistics and records shall be maintained in relation to the provision of Service and used for managing the services and patient care purposes.					
	EVIDENCE OF COMPLIANCE	1. Records are available but not limited to the following:				
		a) workload/census;				
		b) annual report;				
		c) accident/incident reports;				
		d) staffing number and staff profile;				
		e) staff training records;				
		f) data on performance improvement activities, including performance indicators.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
24.1.1.7	Where staff provide direct care to patients, a notation is made in the patient's medical record that care has been given. Where appropriate, response to care is also recorded. Such records are signed, dated, and designation stated.			
	EVIDENCE OF COMPLIANCE			
	1. Notation in the patient's medical record that cares has been given.			
	2. Response to care is recorded.			
	3. Records are signed, dated, and designation stated.			
	Facility Comments:			
24.1.1.8	Where services are provided from an external source there is a written agreement between the external service provider and the Facility stating the requirements for service delivery, including the following: a) formal lines of communication and responsibilities between the external service provider and the Facility; b) provision of adequate numbers of appropriately qualified personnel to perform their duties; c) participation, as appropriate, of the external service provider in committees of the Facility; d) arrangement for adequate pickup and delivery; e) arrangements for after-hours and emergency services; f) mechanisms for dealing with problems in service delivery; g) adequate facilities and equipment for providing the services at the Facility, and at the site of the external service; h) involvement of the external service provider in safety and performance improvement activities of the Facility, as appropriate; i) comply with the appropriate MSQH Standards of Accreditation for that part of the service which functions within the Facility.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Written agreement which include (a) to (i) between the external service provider and the Facility is endorsed, signed and dated.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT				
TOPIC 24.2	<u>HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT</u>			
STANDARD 24.2.1	<i>The Service shall be directed by a person qualified in the specific services and assisted by sufficient qualified support staff to enable fulfilment of the services' aims and objectives and ensure continuing education and development.</i>			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT
				SURVEYOR RATING
24.2.1.1	The Head and staff of the Service shall be individuals qualified by education, training, experience and certification to commensurate with the requirements of the various positions.			
	EVIDENCE OF COMPLIANCE	1. Records on credentials of Head of Service and staff required to fill up the posts within the service (to match the complexity of the Facility and services) and certification/registration.		
		2. Appointment/assignment letters		
		3. Certification		
		4. Training and competency records		
	Facility Comments:			
24.2.1.2	The authority, responsibilities and accountabilities of the Head of Services are clearly delineated and documented.			
	EVIDENCE OF COMPLIANCE	1. Appointment/assignment letter for Head of Service.		
		2. Description of duties and responsibilities.		
	Facility Comments:			
24.2.1.3	Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the need of the services.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Number of staff and qualification should commensurate with workload.				
		2. Staffing pattern				
		3. Duty roster				
		4. Census and statistics				
		Facility Comments:				
24.2.1.4	There are written and dated specific job descriptions for all categories of staff that include: a) qualifications, training, experience and certification required for the position; b) lines of authority; c) accountability, functions and responsibilities; d) reviewed when required and when there is a major change in any of the following: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations. e) administrative and clinical functions.					
	EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e).				
		2. Job description includes specialisation skills				
		3. Relevant privileges granted where applicable				
		4. The job description is acknowledged by the staff and signed by the Head of Service and dated.				
	Facility Comments:					
24.2.1.5	Personnel records on training, staff development, leave and others are maintained for every staff.					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	Note: Staff personal record may be kept in Human Resource Department as per Facility policy.					
	EVIDENCE OF COMPLIANCE	1. Staff personal records include:				
		a) staff biodata;				
		b) qualification and experience;				
		c) training record;				
		d) competency record and privileging;				
		e) leave record;				
		f) confidentiality agreement.				
	Facility Comments:					
24.2.1.6	There is a structured orientation programme where new staff are briefed on their services, operational policies and relevant aspects of the Facility to prepare them for their roles and responsibilities.					
	EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme.				
		2. Records on structured orientation programme				
		3. Orientation Brief				
		4. List of attendance				
	Facility Comments:					
24.2.1.7	There is evidence of training needs assessment and staff development plan which provides the knowledge and skills required for staff to maintain competency in their current positions and future advancement.					
	EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and gaps identified.				
		2. A staff development plan based on training needs assessment is available.				
		3. Training schedule/calendar is in place.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	4. Training module					
	Facility Comments:					
24.2.1.8	There are continuing education activities for staff including medical practitioner to pursue professional interests and to prepare for current and future changes in practice.					
	EVIDENCE OF COMPLIANCE	1. Training calendar includes in-house/external courses/workshop/conferences				
		2. Contents of training programme				
		3. Training records on continuing education activities are kept and maintained for each staff including training in life support.				
		4. Certificate of attendance/degree/post basic training.				
	Facility Comments:					
24.2.1.9	Staff receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.					
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff is completed upon probationary period and as an annual exercise.				
	Facility Comments:					
24.2.1.10	In a teaching hospital, the Service shall provide educational needs and teaching for undergraduates and postgraduates without compromising patient safety and comfort.					
	EVIDENCE OF COMPLIANCE	1. Sufficient skilled and trained staff to provide clinical supervision				
		2. Memorandum of Understanding.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
24.2.1.11	In Facilities which have teaching and research responsibilities, the staff of the Service give their cooperation or participate in the teaching and research programmes.				
	EVIDENCE OF COMPLIANCE	1. Letter of appointment – Local Preceptor/ Clinical Instructor			
		2. Qualification and training records of local preceptor.			
	Facility Comments:				

SURVEY ITEM &SELF-ASSESSMENT						
TOPIC 24.3:		<u>POLICIES AND PROCEDURES</u>				
STANDARD <u>24.3.1</u>		<i>There are documented policies and procedures that reflect current knowledge and practice for the services and are consistent with goals and objectives of the services and relevant regulations and statutory requirements.</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
24.3.1.1 CORE	There are written policies and procedures for the Service which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated.					
	There is a mechanism for and evidence of a periodic review at least once in every three years.					
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for the service.				
		2. Policies and procedures are consistent with regulatory requirements and current standard practices.				
		3. Evidence of periodic review of policies and procedures.				
		4. The policies and procedures are endorsed and dated.				
Facility Comments:						
24.3.1.2	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved. Cross departmental collaboration is practised in developing relevant policies and procedures where applicable					
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.				
		2. Minutes of meeting with evidence of cross reference with other departments				
		3. Documented cross departmental policies				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
24.3.1.3	Current policies and procedures are communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings				
		2. Circulation list and acknowledgement				
	Facility Comments:					
24.3.1.4 CORE	There is evidence of compliance with policies and procedures.					
	EVIDENCE OF COMPLIANCE	1. Compliance with policies and procedures through:				
		a) interview of staff on practices;				
		b) verify with observation on practices;				
		c) results of audit on practices;				
		d) practices in line with established policies and procedures.				
	Facility Comments:					
24.3.1.5	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.					
	EVIDENCE OF COMPLIANCE	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.				
	Facility Comments:					

SURVEY ITEM &SELF-ASSESSMENT							
TOPIC 24.4:		<u>FACILITIES AND EQUIPMENT</u>					
STANDARD <u>24.4.1</u>		<i>Adequate facilities and equipment are available to enable the services to meet their purposes.</i>					
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
24.4.1.1	There are adequate and appropriate facilities and equipment with proper utilisation of space to enable staff to carry out their professional and administrative functions.						
	EVIDENCE OF COMPLIANCE	1.	Adequate and proper utilisation of space.				
		2.	Appropriate type of equipment to match the complexity of services.				
		3.	Easy access and clear exit routes				
		4.	Absence of overcrowding				
	Facility Comments:						
24.4.1.2	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.						
	EVIDENCE OF COMPLIANCE	1.	Testing, commissioning and calibration records (certificates or stickers)				
		2.	Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as evidence of compliance to the relevant standards and Acts.				
		Facility Comments:					
24.4.1.3 CORE	There is evidence that the Facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.						

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	EVIDENCE OF COMPLIANCE	1. Planned Preventive Maintenance records such as schedule, stickers, etc.					
		2. Planned Replacement Programme where applicable					
		3. Complaint records					
		4. Asset inventory					
	Facility Comments:						
24.4.1.4	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.						
	EVIDENCE OF COMPLIANCE	1. User training records					
		2. Competency assessment record					
		3. Letter of authorisation					
		4. List of staff trained and authorised to operate specialised equipment					
	Facility Comments:						

SURVEY ITEM &SELF-ASSESSMENT					
<u>TOPIC 24.5:</u>		<u>SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES</u>			
<u>STANDARD 24.5.1</u>		<i>The Head of Service shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Service.</i>			
		CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
24.5.1.1		There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Service. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.			
EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to (f)				
	2. Records on performance improvement activities.				
	3. Minutes of performance improvement meetings				
	4. Performance improvement studies				
	5. Records on innovation if available				
Facility Comments:					
24.5.1.2		The Head of Service has assigned the responsibilities for planning, monitoring and managing safety and performance improvement to appropriate individual / personnel within the respective services.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes of meetings				
		2. Letter of assignment of responsibilities				
		3. Terms of Reference/Job description				
	Facility Comments:					
24.5.1.3	The Head of the Service shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility. Incidents reported have had Root Cause Analysis done and action taken within the agreed timeframe to prevent recurrence.					
	EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:				
		a) Training of staff				
		b) Policy on incident reporting				
		c) Methodology of incident reporting				
		d) Register/records of incidents				
		2. Completed incident reports				
		3. Root Cause Analysis				
		4. Corrective and preventive action plans				
		5. Remedial measure				
		6. Minutes of meetings				
		7. Acknowledgment by Head of Service and PIC/Hospital Director				
		8. Feedback given to staff regarding incident reporting.				
	Facility Comments:					
24.5.1.4 CORE	There is tracking and trending of at least two (2) specific performance indicators relevant to the service.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored.				
		2. Records on tracking and trending analysis.				
		3. Remedial measures taken where appropriate.				
	Facility Comments:					
24.5.1.5	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.					
	EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff.				
		2. Evidence of feedback via communication on results of performance improvement activities through continuing education activities/meetings.				
		3. Minutes of service meetings				
	Facility Comments:					
24.5.1.6	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.					
	EVIDENCE OF COMPLIANCE	1. Documentation on performance improvement activities and performance indicators.				
		2. Policy statement on anonymity on patients and providers involved in performance improvement activities.				
	Facility Comments:					

SURVEYOR SUMMARY:

OVERALL RISK:

SURVEY ITEM & SELF-ASSESSMENT				
SERVICE STANDARD 25: MEDICAL ASSISTANT SERVICES				
	<u>PREAMBLE</u> <i>Medical Assistants are a group of registered professional healthcare providers within the Malaysian healthcare system and they are governed legally by Act 180, i.e. Medical Assistants (Registration) Act 1977. The title Medical Assistant was changed administratively by the Public Services Department through a circular effective 2nd of July 2009. The change was imperative to reflect the current role, functions and direction of the profession. Medical Assistants (Assistant Medical Officers) are a group of highly trained competent professionals who form an integral part in primary and specialised health services. The scope of services provided encompasses the aspects of promotive, preventive, curative and rehabilitative in health care. It includes the clinical and governance aspects of various disciplines in both medical and public health setting.</i> <i>The services of the Medical Assistant (Assistant Medical Officers) is an integral component in the integrated services of healthcare as partners that aspires to enhance the quality of life and create a healthy and productive Malaysian nation.</i>			
<u>TOPIC 25.1:</u> <u>STANDARD 25.1.1</u>	<u>ORGANISATION AND MANAGEMENT</u> <i>The services of Medical Assistants (Assistant Medical Officers) shall be organised, directed and coordinated with other services to provide professional middle level healthcare uncompromised in terms of quality and standards as required by the relevant authorities.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
25.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the services of Medical Assistants are clearly documented and measurable that indicates safety, quality and patient centered care. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.				
		2. Goals and objectives of the services of Medical Assistants in line with the Facility statements are available, endorsed and dated.				
		3. Evidence of planned review of the above statements.				
		4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc.)				
		5. Achievement of objectives are monitored, reviewed and revised accordingly.				
	Facility Comments:					
25.1.1.2 CORE	The organisational structure of the services of Medical Assistants is clearly represented in one or more organisation charts which:					
	a) Provides a clear representation of the structure, functions and reporting relationships between the Person in Charge (PIC), Head of Service (Chief Medical Assistant), Senior Medical Assistants, Medical Assistants (numbers only), Senior Healthcare Assistants/ <i>Pembantu Perawatan Kesihatan (PPK)</i> and Healthcare Assistants (numbers only).					
	b) is accessible to all staff and clients; c) is revised when there is a major change in any one of the following: i) organisation; ii) functions; iii) reporting relationships; iv) Staffing patterns.					
	EVIDENCE OF COMPLIANCE	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Chief Medical Assistant, all Senior Medical Assistants, Medical Assistants (numbers only), Senior Healthcare Assistants/ <i>Pembantu Perawatan Kesihatan (PPK)</i> and Healthcare Assistants (numbers only).				
		2. At each service level, a unit organisation chart is available which reflects the working relationships between consultants, medical practitioners, Senior Medical Assistants and Senior				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		Healthcare Assistants/ <i>Pembantu Perawatan Kesihatan (PPK)</i> .				
		3. Organisation chart of the service is endorsed, dated and accessible.				
		4. The organisation chart is reviewed when there is a major change in any of the items (c) (i) to (iv).				
	Facility Comments:					
25.1.1.3	Regular staff meetings are held between the Chief Medical Assistant and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the services of Senior Medical Assistants and Senior Healthcare Assistants/ <i>Pembantu Perawatan Kesihatan (PPK)</i> . Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.					
	EVIDENCE OF COMPLIANCE	1. Minutes are accessible, disseminated and acknowledged by the staff.				
		2. Attendance list of members with adequate representatives of the service.				
		3. Frequency of meetings as scheduled at least four (4) times a year				
		4. Discussion and resolutions are implemented. (Problems not solved to be brought forward in the next meeting until resolved.)				
	Facility Comments:					
25.1.1.4	The Chief Medical Assistant is involved in the planning, justification and management of the budget and resource utilisation of the services.					
	EVIDENCE OF	1. Minutes of Facility-wide management meeting				
		2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc.)				
		3. Approved budget and resource				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
25.1.1.5	The Chief Medical Assistant is involved in the assignment of staff.					
	EVIDENCE OF COMPLIANCE	1. Records on staff interview (if applicable)				
		2. Assignment letter of Head of Service (Chief Medical Assistant)				
		3. Job description of Head of Service (Chief Medical Assistant)				
		4. Records on staff assignment/deployment				
		5. Duty roster				
	Facility Comments:					
25.1.1.6	All statistics and records pertaining to the services of Medical Assistants shall be maintained and used for managing the services and patient care purposes.					
	EVIDENCE OF COMPLIANCE	1. Records are available but not limited to following:				
		a) workload/ census for inpatients and outpatients;				
		b) annual report;				
		c) incident and near misses reports				
		d) staffing number and staff profile				
		e) staff training records;				
		f) Data on performance improvement activities, including performance indicators.				
	Facility Comments:					
25.1.1.7	The Chief Medical Assistant heads the planning, development and evaluation of the services of Medical Assistants and Healthcare Assistants/ <i>Pembantu Perawatan Kesihatan (PPK)</i> .					
	EVIDENCE OF COMPLIANCE	1. Chief Medical Assistant's involvement in steering a team in planning, development and implementation of new and existing policies, services and facilities.				
		2. Job description of Chief Medical Assistant.				
		3. Minutes of meetings of steering committee/ team				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
25.1.1.8	There is evidence that the services of Medical Assistants are involved in the development and implementation of new technologies.			
	EVIDENCE OF COMPLIANCE 1. Evidence of involvement of the Medical Assistants on development and implementation of new technologies.			
	2. Minutes of departmental/ management meetings.			
	Facility Comments:			
25.1.1.9	If the Facility provides clinical experience for student Medical Assistants, there should be a comprehensive documented agreement between the Facility and the educational institution detailing the responsibilities of all parties, which shall include: a) time period; b) liability; c) review of terms of contract; d) accountability for clinical practices. e) appointment of local preceptors from among the existing staffs			
	EVIDENCE OF COMPLIANCE 1. Valid Memorandum of Understanding (MOU) or Agreement			
	2. Ratio of Clinical Instructor (CI) and students commensurate with the number of student (1:15)			
	3. Student allocation roster for each discipline			
	4. Standards and Guidelines for Medical Assistant Education Programme.			
	5. Relevant documents of appointment for local preceptors.			
	Facility Comments:			

SURVEY ITEM & SELF-ASSESSMENT				
TOPIC 25.2	<u>HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT</u>			
STANDARD 25.2.1	<i>The Medical Assistant Services shall be directed by suitably qualified and experienced Chief Medical Assistant, and adequately staffed by Medical Assistants and Healthcare Assistants/ Pembantu Perawatan Kesihatan (PPK) to achieve the goals and objectives of the services.</i>			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT
				SURVEYOR RATING
25.2.1.1	All Medical Assistants shall be individuals qualified in terms of education, training, experience, certification and registration under the Medical Assistants (Registration) Act 1977 to commensurate with the requirements of the various positions.			
	EVIDENCE OF COMPLIANCE	1. Records of credentials of Chief Medical Assistant, all Medical Assistants and Healthcare Assistants/ <i>Pembantu Perawatan Kesihatan (PPK)</i> required to fill up the posts within the services (to match the complexity of the Facility and services), certification/ registration and Annual Renewal Certificate [Medical Assistants (Registration) Act 180, 1977].		
		2. Profile of the staff, qualification, experience and overall staffing level.		
		3. List of Medical Assistants with post basic certification in various disciplines.		
		4. Training and competency records		
		5. Records on deployment/ assignment of Medical Assistants according to experience and specialty training		
	Facility Comments:			
25.2.1.2	The Chief Medical Assistant is a member of the Senior Management Team and sits on relevant committees of the Governing Body.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Valid appointment letters and Terms of Reference as member of committees stipulated by the Governing Body.				
		2. Minutes of relevant committee meetings				
	Facility Comments:					
25.2.1.3	The Chief Medical Assistant shall designate suitably qualified Medical Assistants with delegated responsibilities for delivering of services for each unit.					
	EVIDENCE OF COMPLIANCE	1. Copies of records/ duty roster on designated Medical Assistants are assigned to each unit.				
		2. Letters of assignment				
		3. Job description of Senior Medical Assistants				
		4. On-call duty roster of Senior Medical Assistants				
	Facility Comments:					
25.2.1.4	Medical Assistants staffing pattern shall reflect:					
	a) patient needs and patient acuity level of care;					
	b) staffing profile to comply with relevant guidelines and regulatory requirements:					
	i) numbers;					
	ii) credentials and privileges;					
	iii) experience of the various categories of Medical Assistants.					
	c) Contingency plan for staffing (mass casualty incidence, public health emergencies, turnover etc.).					
	EVIDENCE OF COMPLIANCE	1. Records on manpower planning and forecast of staffing needs.				
		2. Qualified staff and patient ratio meets the Ministry of Health (MoH) norms.				
		3. Staff credentials and privileges.				
		4. Verification of staffing needs in units as reflected by:				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		a) current assigned duty roster;				
		b) patient acuity level of care;				
		c) skills mix;				
		d) written contingency plan (mass casualty incidence, public emergencies, turnover etc.).				
	Facility Comments:					
25.2.1.5	There are written and dated specific job descriptions for all Medical Assistants that include: a) qualifications, training, experience and certification required for the position; b) lines of authority; c) accountabilities, functions and responsibilities; d) review when required and when there is a major change in any of the following: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations. e) administrative, teaching and clinical functions.					
EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff but not limited to items (a) to (e).					
	2. Job description includes specialisation skills and relevant privileges granted.					
	3. The job description is acknowledged by the staff and signed by the Head of Service/ Unit, Chief Medical Assistant and dated.					
Facility Comments:						

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
25.2.1.6 CORE	The Chief Medical Assistant shall be responsible for the management, supervision, training and performance appraisal of Healthcare Assistants/ <i>Pembantu Perawatan Kesihatan (PPK)</i> .				
	EVIDENCE OF COMPLIANCE	1. Letters of assignment of Healthcare Assistants			
		2. Job description of Healthcare Assistants according to assigned areas of work.			
		3. Staff profile of individual Healthcare Assistant and overall staffing level.			
		4. Training records and list of Healthcare Assistants with Level 1 and Level 2 Certificate.			
		5. Duty roster of Healthcare Assistants in various disciplines.			
		6. Written contingency plan (mass casualty incidence, public health emergencies, turnover etc.).			
		7. Documented Supervisory Report on Healthcare Assistants.			
		8. Performance appraisal for Healthcare Assistants are completed upon probationary period and as an annual exercise.			
	Facility Comments:				
25.2.1.7 CORE	There is structured orientation programme for all newly appointed Medical Assistants, Healthcare Assistant/ <i>Pembantu Perawatan Kesihatan (PPK)</i> and for those new to specific areas which shall include the followings: a) explanation of the Goals and Objectives, policies and procedures of the Facility, Medical Assistant Services and Healthcare Assistant Services; b) lines of authority and areas of responsibility; c) explanation of particular duties and functions; d) explanation of the methods of assigning specific care and the standards of practice; e) handover communications; f) processes for resolving practice dilemmas; g) information about safety procedures; h) training in basic/ advanced life support techniques; i) methods of obtaining appropriate resource materials;				

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS				
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING			
	j) Annual Renewal Certificate (applicable to Medical Assistant only) k) education on Patient and Family Rights; l) education on MSQH standard requirements; m) fire safety and disaster management; n) patient safety; o) staff appraisal procedures. ~~for the Medical Assistant Services~~						
	EVIDENCE OF COMPLIANCE				1. Policy requiring all new staff to attend a structured orientation programme.		
					2. Records of all new staff who attend a structured orientation programme.		
					3. There is a standard orientation programme with relevant topics not limited to topics covered from (a) to (o) and supported by an individual area/unit specific orientation programme.		
	Facility Comments:						
25.2.1.8	The Chief Medical Assistant ensures all Medical Assistants and Healthcare Assistants/ <i>Pembantu Perawatan Kesihatan (PPK)</i> receive evaluation of their performance at the completion of the probationary period and annually.						
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for all Medical Assistants and healthcare assistants is completed upon probationary period and as an annual exercise.					
		Facility Comments:					
25.2.1.9	There is evidence of training needs assessment and staff development plan which provide the knowledge and skills required for staff to maintain competency in their current positions and future advancement.						

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out.				
		2. A staff development plan based on training needs assessment is available.				
		3. Training schedule/ calendar is in place.				
		4. Training module.				
	Facility Comments:					
25.2.1.10	There are continuing medical education and Continues Professional Development activities for staff to pursue professional interests and to prepare for current and future changes in practice.					
	EVIDENCE OF COMPLIANCE	1. Training calendar includes in-house/ external courses/ workshop/ conferences				
		2. Contents of training programme				
		3. Training records on Continuing Medical Education and Continuing Professional Development activities are kept and maintained for each staff.				
		4. Certificate of attendance/ degree/ post basic training.				
	Facility Comments:					
25.2.1.11	Personnel records on training, staff development, leave and others are maintained for every staff. Note: Staff personal record may be kept in Human Resource Department as per Facility policy.					
	EVIDENCE OF COMPLIANCE	1. Staff personal records include:				
		a) staff biodata;				
		b) qualification and experience;				
		c) evidence of current registration;				
		d) training record;				
	e) competency record and privileging;					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		f) leave record;				
		g) confidentiality agreement				
	Facility Comments:					
25.2.1.12	In a Facility where Medical Assistant education programmes are conducted, the Chief Medical Assistant shall ensure that there are sufficient skilled clinical instructors with right credentials, experience, certification and privileged to provide clinical guidance and supervision of students.					
	EVIDENCE OF COMPLIANCE	1. Skilled Clinical Medical Assistant Instructors with student ratio are appropriately met (1:15).				
		2. Written evidence that continuous effort has been taken to ensure that sufficient skilled Clinical Instructors are available at all times.				
		3. The Clinical Instructors have the right credentials and are privileged.				
		4. Signed Code of Conduct by Clinical Instructor.				
		5. Minutes of joint meetings between the Chief Medical Assistant and the training college/ institution.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
25.2.1.13 CORE	The Services of Medical Assistant shall ensure the establishment of a mechanism which includes requirements, methodology and certification for credentialing and privileging for Medical Assistants in specialised areas for specific procedures. The mechanism taken by the Medical Assistants shall adhere to the following:			
	a) the written policies and procedures documents the criteria for privileging;			
	b) the decisions made are objective, fair and impartial and consistent with written policies, procedures and criteria;			
	c) the granting of privileges for a specified period of time;			
	d) the allocation of privileges in such a way that each staff functions within a specified area of competence;			
	e) the granting of privileges is approved by the Credentialing and Privileging Committee and certified by the Person in Charge (PIC)/ Governing Body.			
EVIDENCE OF COMPLIANCE	1. Documented policies and procedures are established to govern the credentialing and privileging processes for Medical Assistants which are not limited to item (a) to (e).			
	2. There is a systematic validation process for each individual staff member of their credentials.			
	3. Skill competency is assessed regularly.			
	4. Formal letters of assignment or certificate of privileging with stipulated timeline are issued and reviewed accordingly.			
Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT				
TOPIC 25.3:	<u>POLICIES AND PROCEDURES</u>			
STANDARD 25.3.1	<i>There are written and dated policies and procedures for all services provided by Medical Assistants and Healthcare Assistants/ Pembantu Perawatan Kesihatan (PPK). These policies and procedures reflect current standards of services and practice, relevant regulations, statutory requirements and the purposes of the services.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
25.3.1.1 CORE	There are written policies and procedures for services provided by Medical Assistants and Healthcare Assistants/Pembantu Perawatan Kesihatan (PPK) which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices which include: a) policies and procedures, applicable laws and regulations that guide the medical care of all patients; b) policies and procedures that guide the care of high risk patients and high risk services: i) Pre Hospital Care; ii) Disaster/ Mass Casualty Management; iii) emergency patients; iv) use of resuscitation services; v) administration of blood and blood products; vi) patients on life support/comatose; vii) patients with communicable disease; viii) immune-compromised patients; ix) patients on dialysis; x) care of patients on restraints/violence; xi) high risk medications (Radio-iodine Oncology); xii) substance abuse (Methadone Clinic); xiii) medico legal cases; xiv) forensic services; xv) community psychiatry. xvi) Public Health Emergency.			

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	These policies and procedures are signed, authorised and dated. There is a mechanism for and evidence of a periodic review at least once in every three years.					
	EVIDENCE OF COMPLIANCE	1. Documented Policies and Procedures, Protocols, Manuals and Guidelines are available to guide Medical Assistants for:				
		a) general care of all patients;				
		b) high risk patients as those mentioned in but not limited to (b).				
		2. Policies and procedures are consistent with the regulatory requirements and current standard practices.				
		3. Evidence of periodic review of policies and procedures.				
		4. The policies and procedures are endorsed and dated.				
	Facility Comments:					
25.3.1.2	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, nursing staff, Management and where required with other external service providers and with reference to relevant sources involved. Cross departmental collaboration is practiced in developing relevant policies and procedures where applicable.					
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.				
		2. Minutes of meeting with evidence of cross reference with other departments				
		3. Cross departmental policies and procedures, e.g. Inter-Hospital Transfer in which a policy is developed, e.g. between Ambulance and Transport Services (CMA), Porterage Services.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
25.3.1.3	Current policies and procedures are communicated to all staff of the Medical Assistant Services.			
	EVIDENCE OF COMPLIANCE			
	1. Training and briefing on the current policies and procedures/ Minutes of meetings.			
	2. Circulation list and acknowledgement.			
	Facility Comments:			
25.3.1.4 CORE	There is evidence of compliance with policies and procedures.			
	EVIDENCE OF COMPLIANCE			
	1. Compliance with policies and procedures through:			
	a) interview of staff on practices;			
	b) verify with observation of practices;			
	c) results on audit on practices;			
	d) practices in line with established policies and procedures.			
	Facility Comments:			
25.3.1.5	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff of Medical Assistant Services.			
	EVIDENCE OF COMPLIANCE			
	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site/workstation for staff reference.			
	Facility Comments:			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
25.3.1.6	The Chief Medical Assistant is responsible for the organisation, documentation and implementation of policies and procedures for the Medical Assistant Services.				
	EVIDENCE OF COMPLIANCE	1. Policies and procedures for the Medical Assistant Services are endorsed by the Chief Medical Assistant.			
	Facility Comments:				
25.3.1.7	The Medical Assistants participate in planning, decision making and formulation of policies of the Facility.				
	EVIDENCE OF COMPLIANCE	1. List of committees where the Chief Medical Assistant is involved.			
		2. Minutes of Management meetings			
	Facility Comments:				
25.3.1.8 CORE	Medical Assistants practice is in accordance with nationally accepted standards based on current evidences: a) initial assessment of patients and immediate intervention deemed necessary where relevant, i.e. triaging of patients for emergency services, pre-hospital care and dialysis patients; b) administering treatment and performing procedures as ordered by the medical practitioners; c) reviewing and reporting changes in the progress of the patient where relevant; d) completing the planned management with proper documentation; e) planning follow up that reflects continuity of care where required; f) patient education which shall be documented, e.g. Outpatient Clinic, Orthopedics, Dermatology and Eye Clinics; Hemodialysis and Asthma patients.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	EVIDENCE OF COMPLIANCE	1. Evidence of implementation and documentation of practices (a) to (f); signed/ stamped and dated, e.g. patient's medical records.						
		2. Compliance to relevant National Patient Safety Goals.						
	Facility Comments:							

SURVEY ITEM & SELF-ASSESSMENT								
TOPIC 25.4:		<u>FACILITIES AND EQUIPMENT</u>						
<u>STANDARD 25.4.1</u>		<i>There are adequate and appropriate facilities and equipment for providing safe and efficient medical assistants’ services according to standards set by the relevant authorities and regulatory requirements.</i>						
		CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
25.4.1.1		There are adequate and appropriate facilities and equipment with proper utilisation of space to allow the Medical Assistants to carry out their services safely and efficiently.						
EVIDENCE OF COMPLIANCE		1. Adequate and proper utilisation of space.						
		2. Appropriate type of equipment to match the complexity of the Medical Assistant Services.						
		3. Adequate facilities and equipment for Medical Assistants at each assigned patient care area for safe care. (e.g. defibrillators, emergency cart, hand washing facilities etc.)						
		4. Easy access and clear exit routes						
		5. Absence of overcrowding						
		Facility Comments:						
25.4.1.2		Medical Assistants are provided with sufficient supplies and equipment at all times, including appropriate personal protective equipment.						
EVIDENCE OF COMPLIANCE		1. Adequate equipment and supplies.						
		2. Equipment are replaced in a planned and systematic manner.						
		3. Stock inventory including personal protective equipment are according to par level.						
		4. Accessibility of critical equipment and consumables at all times						
		5. Equipment has valid Planned Preventive Maintenance (PPM)						
		Facility Comments:						

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
25.4.1.3	Facilities which provide training shall have specific areas for training and rooms for tutorial.				
	EVIDENCE OF COMPLIANCE	1. Availability of training/ tutorial areas/ rooms.			
	Facility Comments:				

SURVEY ITEM & SELF-ASSESSMENT					
<u>TOPIC</u> <u>25.5:</u>		<u>SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES</u>			
<u>STANDARD</u> <u>25.5.1</u>		<i>The Chief Medical Assistant shall ensure the provision of quality performance and safety of patients with the staff involvement in continuous safety and performance improvement activities of the Medical Assistant Services.</i>			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
25.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.				
	EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to (f)			
		2. Records on performance improvement activities.			
		3. Minutes of performance improvement meetings.			
		4. Performance improvement studies.			
		5. Records of innovation if available.			
	Facility Comments:				
25.5.1.2	The Chief Medical Assistant has assigned the responsibilities for planning, monitoring and managing safety and performance improvement activities to appropriate individual/ personnel within the respective services.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes of meetings				
		2. Letter of assignment of responsibilities				
		3. Job description				
	Facility Comments:					
25.5.1.3 CORE	The Chief Medical Assistant shall ensure that the staff are trained and complete incident reports (where applicable) which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility. Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.					
EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:					
	a) Training of staff					
	b) Policy on incident reporting					
	c) Methodology of incident reporting					
	d) Register/ records of incidents					
	2. Completed incident reports					
	3. Corrective and preventive action plans					
	4. Remedial measure					
	5. Minutes of meetings					
	6. Acknowledgment by Chief Assistant Medical Officer and PIC/					
	7. Hospital Director					
	8. Feedback given to staff regarding incident reporting.					
Facility Comments:						

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
25.5.1.4 CORE	The Medical Assistant Services shall conduct tracking and trending of the following specific performance indicators:			
	i. Number of fire drill that has been carried out by the hospital in the corresponding year: a. Fire Drill at hospital level: Once a year b. Tabletop Exercise at hospital level: Twice a year (Once in 6 month)			
	ii. Dispatch and Ambulance Preparedness of Primary Responses (Target: ≥90%)			
	iii. Percentage of Medical Assistants in Emergency Services trained in Advanced Life Support (ALS) (Target: Non-specialist hospital: ≥30% Specialist hospital: ≥50%)			
	iv. Percentage of Medical Assistants with post basic qualification and advance training in relevant disciplines. Target: ≥ 40%			
	v. Peak Flow Rate (PEFR) Implementation for Asthma Patients in Asthma Bay by Medical Assistant (Target: >80% number of all asthma patients with Pre and Post PEFR treated in Asthma Bay)			
EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored.			
	2. Reports on Fire Drill and Tabletop Exercise			
	3. Remedial measures taken where appropriate			
	Facility Comments:			
25.5.1.5	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff.				
		2. Evidence of feedback via communication on results of performance improvement activities through continuing medical education activities/ meetings.				
		3. Minutes of service/ unit/ committee meetings				
	Facility Comments:					
25.5.1.6	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.					
	EVIDENCE OF COMPLIANCE	1. Documentations on performance improvement activities and performance indicators.				
		2. Policy statement on anonymity on patients and providers involved in performance improvement activities				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT	
TOPIC 25.6:	<u>SPECIAL REQUIREMENTS</u> <i>Medical Assistants play roles of specially trained healthcare staff providing a high standard of care for inpatients (where relevant) and ambulatory care to the community in specific clinical disciplines. Medical Assistants also coordinate with other services to provide support for the Environmental and Safety Services of the Facility. The most common areas that Medical Assistants are involved include the following:</i> 1. <i>Role in Environmental and Safety Services</i> 2. <i>Role as Fire Safety Officer</i> 3. <i>Role in External/ Internal Disaster Management</i> 4. <i>Role in Clinical Supervision</i> 5. <i>Roles in Specific Clinical Services</i>
STANDARD 25.6.1	<u>Role in Environmental and Safety Services</u> <i>The Chief Medical Assistant shall assign designated Medical Assistant to oversee the activities related to Environmental and Safety Services, working in collaboration with the Head of Environmental and Safety Services and coordinated by appropriate Committees as to provide optimum support to the objectives of the Facility in terms of the safety needs of the Facility, patients, staff and visitors.</i>

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
25.6.1.1	The role of assigned Medical Assistant shall address but not limited to the following: a) Occupational Safety and Health b) Fire Safety c) Disaster Management i) External Disaster ii) Internal Disaster d) Hazardous Material and Recyclable Waste Management e) Security Services f) Vector and Pest Control <i>*(a), (e) & (f) where applicable</i>			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Operational policies of the Environmental and Safety Services address activities (a) to (f).				
		2. Terms of reference on the role and responsibilities of assigned Medical Assistant to address activities (a) to (f).				
	Facility Comments:					
25.6.1.2	There is clear evidence of coordination and cooperation amongst the various Medical Assistants pertaining to Environmental and Safety Services. Records on the coordination meetings and discussions shall be kept and made accessible to relevant staff when required.					
	EVIDENCE OF COMPLIANCE	1. Minutes of meetings of the coordination meetings.				
	Facility Comments:					
25.6.1.3 CORE	The assigned Medical Assistant to the Environmental and Safety Services are appropriately qualified, trained, experienced and/ or certified where required.					
	EVIDENCE OF COMPLIANCE	1. Attendance to relevant training.				
		2. Staff training records				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT					
STANDARD 25.6.2	Role as Fire Safety Officer <i>The Person In Charge (PIC) of the Facility shall ensure the appointment of the Chief Medical Assistant to the Facility's Fire Safety Committee and as the designated Fire Safety Officer for the Facility as per Circular from Director General of Health Services Malaysia [KKM.600.27/14/39 JLD 2(55)]</i>				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	
				SURVEYOR RATING	
25.6.2.1 CORE	The Chief Medical Assistant shall be assigned as a permanent member to the Facility's Fire Safety Committee and as the Fire Safety Officer for the Facility.				
	EVIDENCE OF COMPLIANCE	1. Letter of assignment of Chief Medical Assistant as member of Fire Safety Committee and Fire Safety Officer with Terms of Reference.			
		2. Appropriate training and experience as Fire Safety Officer.			
	Facility Comments:				
25.6.2.2 CORE	The Chief Medical Assistant who is the Fire Safety Officer shall prepare, implement and review the Fire Prevention and Surveillance Plan.				
	EVIDENCE OF COMPLIANCE	1. Fire Prevention and Surveillance Plans that have been endorsed and dated by the Person in Charge (PIC).			
	Facility Comments:				
25.6.2.3	The Chief Medical Assistant who is the Fire Safety Officer shall organise and implement training for fire safety coordinators, firefighting and rescue team members and other personnel involved.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Fire Safety training schedules				
		2. Certification/ list of attendance				
	Facility Comments:					
25.6.2.4	Fire drills are conducted at least once a year based on the fire prevention and control plan.					
	EVIDENCE OF COMPLIANCE	1. Reports on fire drills				
		2. Identifying shortfalls				
		3. Minutes of meetings of pre and post drills				
		4. Remedial actions planned and implemented.				
	Facility Comments:					
25.6.2.5	The Fire Safety Officer shall coordinate manpower to help in rescuing and evacuation of victims and equipment to a safer area.					
	EVIDENCE OF COMPLIANCE	1. List of identified personnel for the purpose.				
		2. Evidence of appropriate training to the selected personnel.				
	Facility Comments:					
25.6.2.6 CORE	The Fire Safety Officer shall conduct Fire Audit in the wards/ units regularly.					
	EVIDENCE OF COMPLIANCE	1. Audit Schedules				
		2. List of Auditors				
		3. Reports of audits				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT	
STANDARD 25.6.3	Role in External/ Internal Disaster Management <i>The Chief Medical Assistant plays a critical role in emergency preparedness and shall be assigned to oversee the activities related to External and Internal Disaster Management, working in collaboration with the Head of Services within the Facility and other relevant agencies. He shall coordinate appropriate Committees as to provide optimum support to the objectives of the Facility in terms of Reduce Damages and Deaths, Reduce Personal Suffering, Speed Recovery and Protect Victims in the event of a disaster.</i>

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
25.6.3.1	The Person In Charge (PIC) of the Facility shall ensure the assignment of the Chief Medical Assistant as the secretary of the External/ Internal Disaster Management Committee (where applicable).			
	EVIDENCE OF COMPLIANCE 1. Valid appointment letters and Terms of Reference as member of committees stipulated by the Governing Body.			
	2. Minutes of relevant committee meetings			
	Facility Comments:			
25.6.3.2 CORE	The Chief Medical Assistant shall coordinate in the preparation, implementation and review of the External/ Internal Disaster Management Policy.			
	EVIDENCE OF COMPLIANCE 1. The Internal/ External Disaster Management Plans that has been endorsed and dated by the Person In Charge (PIC).			
	Facility Comments:			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
25.6.3.3	The Chief Medical Assistant shall organise and implement training for internal/ external disaster management teams.					
	EVIDENCE OF COMPLIANCE	1. Internal/ External Disaster Management Training schedules				
		2. Certification/ list of attendance				
	Facility Comments:					
25.6.3.4	Internal/ External Disaster drills are conducted at least once a year.					
	EVIDENCE OF COMPLIANCE	1. Reports on disaster drills				
		2. Identifying shortfalls				
		3. Minutes of meetings of pre and post drills				
		4. Remedial actions planned and implemented.				
	Facility Comments:					
25.6.3.5 CORE	The Chief Medical Assistant shall coordinate manpower to help in rescuing and evacuation of victims and equipment to a safer area.					
	EVIDENCE OF COMPLIANCE	1. List of identified personnel for the purpose.				
		2. Evidence of appropriate training to the selected personnel.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT	
STANDARD 25.6.4	<u>Role in Clinical Supervision</u> <i>The Chief Medical Assistant shall ensure clinical supervision is carried out as part of best practice to facilitate and develop the knowledge and competence of individual practitioners in order to provide high quality care and safety among patients, public, staff and service users. Supervision's objectives are "normative" (e.g. quality control), "restorative" (e.g. encourage emotional processing) and "formative" (e.g. maintaining and facilitating supervisees' competence, capability and general effectiveness).</i> <i>Reference:</i> <i>Milne (2007) defined clinical supervision as: "The formal provision, by approved supervisors, of a relationship-based education and training that is work-focused and which manages, supports, develops and evaluates the work of colleague/s. The main methods that supervisors use are corrective feedback on the supervisee's performance, teaching and collaborative goal-setting. It therefore differs from related activities, such as mentoring and coaching, by incorporating an evaluative component.</i>

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
25.6.4.1 CORE	The Chief Medical Assistant shall carry out clinical supervision rounds periodically in an appropriate time frame to facilitate and develop the knowledge and competence of individual practitioners in order to provide high quality care and safety among patients, public, staff and service users.				
	EVIDENCE OF COMPLIANCE	1. An approved supervisory schedule/ roster for a year			
		2. Records/ reports on supervision in clinical areas			
		3. Evidence of review on records/ reports on supervision in clinical areas by management.			
	Facility Comments:				
25.6.4.2	The Chief Medical Assistant shall ensure that the clinical practice of the Medical Assistants is according to the standard operating procedures.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Standard operating procedures and guidelines relevant to the clinical practice				
		2. Evidence of adherence to the standard operating procedures.				
		3. Records of non-adherence and the remedial actions.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT	
STANDARD 25.6.5	<u>Roles in Specific Clinical Services</u> <i>The Medical Assistant Services shall also coordinate with other services such as clinical services, nursing services or independently in the Facility to provide a high standard of inpatient care (where relevant) and ambulatory/ outpatient services covering appropriateness of clinical care in the following specific disciplines:</i> 1. <i>Emergency & Trauma Services and Pre Hospital Care</i> 2. <i>Hemodialysis Services</i> 3. <i>Community Psychiatry Services</i> 4. <i>Hospital Psychiatry Services</i> 5. <i>Intensive Care Services and Hemodynamic Services</i> 6. <i>Orthopedic Services</i> 7. <i>Ophthalmology Services</i> 8. <i>Otorhinolaryngology Services</i> 9. <i>Peri-Anaesthesia and Anesthetic Services (Sabah & Sarawak)</i> 10. <i>Forensic/ Mortuary Services</i> 11. <i>Invasive and Non-Invasive Cardiac Laboratory</i> 12. <i>Neurophysiology Services</i> 13. <i>Urology Services</i> 14. <i>Cardiothoracic Surgery Services</i> 15. <i>Neurology Services - Sleep Laboratory</i> 16. <i>Hand & Microsurgery Services</i> 17. <i>Hepatobiliary Surgery Services</i> 18. <i>Plastic Surgery Services</i> 19. <i>Dermatology Services</i> 20. <i>Rehabilitation Medicine Services</i> 21. <i>Oncology Services</i> 22. <i>Nuclear Medicine Services</i> 23. <i>Respiratory Medicine Services</i> 24. <i>Endoscopy Services</i> 25. <i>Neurosurgical Services</i> <i>In addition to the above, the Medical Assistant Services also conduct teaching and training, research and audit activities where applicable.</i>

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
25.6.5.1 CORE	The Chief Medical Assistant shall ensure that appropriately qualified and competent Medical Assistants are deployed as per requirements of the specialised services. <u>1. Emergency & Trauma Services and Pre Hospital Care</u> i) All Medical Assistants shall be trained in Basic Life Support (BLS) within two (2) months after being placed in the Emergency Services ii) All Medical Assistants in the Emergency Services shall continuously participate in Advanced Life Saving and Trauma Programme (e.g. Malaysian Trauma Life Support (MTLS) Advanced Life Support (ALS)/ Advanced Cardiac Life Support (ACLS)/ Pediatric Advanced Life Support (PALS)] or any advanced programme done by Emergency Services within two (2) years after being placed in the Emergency Services. <u>2. Haemodialysis Services</u> i) All Medical Assistants assigned to work in Hemodialysis Unit should undergo at least three (3) months of tagging and shall be trained in Basic Life Support (BLS) within two (2) months after being placed in the Hemodialysis Unit. <u>3. Psychiatry Services</u> i) All Medical Assistants shall attend post basic (Advanced Dip in Mental Health Care) within three (3) years posted to a Psychiatric Unit/ Department. Medical Assistants who assist in Electro convulsive therapy (ECT) shall possess a post basic certificate in Peri Anesthesia/ Anesthesia <u>4. Anaesthesia and Intensive Care Services</u> i) All Medical Assistants shall be trained in Basic Life Support (BLS) within two (2) month after being placed in the Anesthesia and Intensive Care Services. ii) All Medical Assistants who works more than three (3) years in the Anesthesia and Intensive Care Services should attend post basic training in Peri-Anaesthesia or Advance Diploma Intensive Care (Technology) or Anesthesia (Sabah & Sarawak) iii) All Medical Assistants (Intensive Care Technologists, Anesthetic Assistant and			

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	Technologists) who work more than three (3) years in the Anesthesia and Intensive Care Services shall be credentialed at the Ministry of Health (MOH) level by National Credentialing Committee. iv) All Medical Assistants shall be privileged at the hospital level after completion of log books (within 6 months – 12 months) after being placed in the Anesthesia and Intensive Care Services. 5. <u>Orthopedic, Ophthalmology and Otorhinolaryngology Services</u> i) All Medical Assistants shall participate in Departmental/ State/ National level orthopedic courses or any post basic programme organised by the Ministry of Health. ii) All Medical Assistants shall be trained in Basic Life Support (BLS) within two (2) months after being placed in the Ophthalmology Services especially those who are involved in Fundus photo Angiogram procedures. iii) All Medical Assistants shall attend post basic course in Ophthalmic Nursing within three (3) years of being posted in the Ophthalmology Services 6. <u>Neurophysiology Services</u> i) All Medical Assistants assigned to work in the specialist department should undergo at least three (3) months of tagging and attend a post basic course in Neurophysiology Clinical within three (3) years. 7. <u>Cardiothoracic Surgery Services</u> i) All Medical Assistants assigned to work in Cardiothoracic Unit should undergo at least three (3) months of tagging and shall be trained in Basic Life Support (BLS) within three (3) years after being placed in the Cardiothoracic Surgery Department/Unit. 8. <u>Endoscopy Services</u> i) All Medical Assistants shall be trained in Gastrointestinal Endoscopy at least two (2) months after being placed in the Endoscopy Unit. ii) All Medical Assistants assigned to work in an endoscopic unit should undergo at			

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	least three (3) months of tagging and attend a post basic course in Endoscopy Clinical within three (3) years.					
	iii) All Medical Assistants in the Endoscopy Unit shall continuously participate in any programme organised by the Malaysian Society of Gastrointestinal and Hepatobiliary.					
	9.Neurosurgical Services					
	i) All Medical Assistants assigned to work in the specialist department should undergo at least three (3) months of tagging and attend a relevant post basic course (Neuroscience, Perioperative) within three (3) years.					
	EVIDENCE OF COMPLIANCE				1. Written policies on the specific requirements for specialised training for Medical Assistants.	
					2. Records of training/ tagging log books of Medical Assistants.	
					3. Post Basic Certificates	
					4. Reports of Chief Medical Assistant's supervision of Medical Assistants deployed to specific clinical disciplines.	
5. Documentation on remedial actions found during the supervision and audit on clinical practice.						
Facility Comments:						
25.6.5.2 CORE	<u>Forensic Services/ Mortuary Services</u> The Chief Medical Assistant shall ensure that Medical Assistants working in the Forensic Services have adequate experience in the services before being allowed to work independently and they are made aware of medico legal implications that may arise in the course of their work. All Medical Assistants assigned to work in the Forensic Services of non-specialist facility should undergo at least two (2) weeks of attachment in a specialist facility.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	EVIDENCE OF COMPLIANCE	1. Records on attachment training in facility with specialist services						
		2. Approval by the relevant authority to confirm that the Medical Assistants allowed to work independently in the Forensic Services of non-specialist facility.						
	Facility Comments:							
25.6.5.3	All Medical Assistants in the Forensic Services shall work under supervision for at least three (3) months before being allowed to work independently.							
	EVIDENCE OF COMPLIANCE	1. Records of probationary period of all Medical Assistants						
		2. Approval by the relevant authority in allowing the Medical Assistants to work independently.						
	Facility Comments:							

SURVEYOR SUMMARY:

OVERALL RISK:

SURVEY ITEM & SELF-ASSESSMENT			
SERVICE STANDARD 26 : STANDARDS FOR CLINICAL RESEARCH CENTRE (CRC)			
	<u>PREAMBLE</u> <i>Clinical research is a branch of healthcare science that determines the safety and effectiveness (efficacy) of medications, devices, diagnostic products and treatment regimens intended for human use. These may be used for prevention, treatment, diagnosis or for relieving symptoms of a disease.</i> <i>Clinical research is often conducted at academic medical centers and affiliated research study sites, i.e. hospitals. The Clinical Research Centre (CRC) is organised and administered to support and facilitate research activities in the Facility according to the goals and objectives of the Facility Clinical Research Centre (FCRC) and to meet the needs of the clients being served.</i> <i>The FCRC shall be directed by a person qualified in the specific services and assisted by sufficient qualified support staff to enable fulfilment of the FCRC's goals and objectives and ensure continuing education and development.</i>		
<u>TOPIC 26.1:</u> <u>STANDARD 26.1.1</u>	<u>ORGANISATION AND MANAGEMENT</u> <i>The Clinical Research Centre (CRC) is organised and administered to support and facilitate research activities in the Facility according to the goals and objectives of the Facility Clinical Research Centre (FCRC) and to meet the needs of the clients being served.</i>		
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT
			SURVEYOR RATING
26.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Clinical Research Centre are clearly documented and measurable that indicates safety, quality and patient centred care. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.		

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.				
		2. Goals and objectives of the Clinical Research Centre in line with the Facility statements are available, endorsed and dated.				
		3. Evidence of planned reviews of the above statements.				
		4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)				
		5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.				
	Facility Comments:					
26.1.1.2 CORE	There is an organisation chart which:					
	a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head and staff of Clinical Research Centre;					
	b) provide a clear representation of the structure, functions and reporting relationships between the Clinical Research Center and Hospital organisation;					
	c) is accessible to all staff and clients;					
	d) includes off-site services if applicable;					
	e) is revised when there is a major change in any of the following:					
	i) organisation;					
EVIDENCE OF COMPLIANCE	ii) functions;					
	iii) reporting relationships;					
	iv) staffing patterns.					
EVIDENCE OF COMPLIANCE	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head and staff of Clinical Research Centre.					
	2. Clearly delineated current organisation chart with line of functions and reporting relationships between Clinical Research Centre and Hospital organization					
	3. Organisation chart of the service is endorsed, dated and accessible					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	4. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).					
	Facility Comments:					
26.1.1.3	Regular staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Facility Clinical Research Centre (FCRC). Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.					
	EVIDENCE OF COMPLIANCE	1. Minutes are accessible, disseminated and acknowledged by the staff.				
		2. Attendance list of members with adequate representatives of the service.				
		3. Frequency of meetings as scheduled.				
		4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).				
	Facility Comments:					
26.1.1.4	The Head of FCRC is involved in the planning, justification and management of the budget and resource utilisation of the services.					
	EVIDENCE OF COMPLIANCE	1. Minutes of Facility-wide management meeting				
		2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service.				
		3. Approved budget and resources.				
	Facility Comments:					
26.1.1.5	The Head of FCRC is involved in the appointment and/OR assignment of staff.					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	EVIDENCE OF COMPLIANCE	1. Records on staff interview (if applicable)					
		2. Appointment/assignment letter of Head of Service					
		3. Job description of Head of Service					
		4. Records on staff deployment					
		5. Duty roster					
	Facility Comments:						
26.1.1.6	Appropriate statistics and records shall be maintained in relation to the provision of FCRC and used for managing the services and patient care purposes.						
	EVIDENCE OF COMPLIANCE	1. Records are available for CRC provision but not limited to the following:					
		a) workload (research consultation, National Medical Research Register (NMRR) Registration, research training, Hospital Research Review Committee);					
		b) staffing number and staff profile;					
		c) staff training and human resource records;					
		d) complaints and report;					
		e) research database;					
		f) data on performance improvement activities, including performance indicators.					
	Facility Comments:						
26.1.1.7	Where services are obtained from an external source, there is a written agreement between the external service provider and the Facility stating the requirements for service delivery, including the following: a) formal lines of communication and responsibilities between the external service provider and the FCRC; b) provision of adequate numbers of appropriately qualified personnel to perform their duties; c) participation, as appropriate, of the external service provider in committees of the FCRC; d) arrangement for adequate pickup and delivery; e) arrangements for after-hours and emergency services;						

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS			
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	f) mechanisms for dealing with problems in service delivery; g) adequate facilities and equipment for providing the services at the FCRC, and at the site of the external service; h) involvement of the external service provider in safety and performance improvement activities of the FCRC, as appropriate; i) comply with the appropriate MSQH Standards of Accreditation for that part of the service which functions within the FCRC. j) visits to the facilities of the external service provider by the staff of FCRC to ensure requirements of standards are met.					
	EVIDENCE OF COMPLIANCE	1. The Contract Agreement between the Facility and the external service provider(s) is in place and covers item (a) to (i).				
		2. Records on communication and responsibilities between the external service provider and the FCRC.				
		3. Record of qualified personnel to perform their duties.				
		4. Documentation for sample handling and transportation to external source (e.g. central laboratory in Singapore/Thailand, etc.)				
		5. Documentation arrangements for after-hours and emergency services, e.g. severe adverse event/drug reaction/ Suspected Unexpected Serious Adverse Reaction (SUSAR) and report to relevant authority within specific time				
		6. Documentation of relevant authority, e.g. research sponsor/Clinical Research Associate (CRA)/ Clinical Research Organization (CRO)/Medical Research Ethics Committee (MREC) and etc for safety and performance improvement activities, e.g. monitoring of Investigator product , consent , research data and etc.				
		7. Records on visit to facilities of the external service provider by the staff of FCRC, e.g. if involve multi-centre study particularly Investigator Initiated Research (IIR).				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT				
TOPIC 26.2	HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT			
STANDARD 26.2.1	<i>The FCRC shall be directed by a person qualified in the specific services and assisted by sufficient qualified support staff (permanent/contract/study coordinator) to enable fulfilment of the FCRC's goals and objectives and ensure continuing education and development.</i>			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT
				SURVEYOR RATING
26.2.1.1 CORE	The Head and staff of the FCRC shall be individuals qualified by education, training, experience and certification to commensurate with the requirements of the various positions.			
	EVIDENCE OF COMPLIANCE	1. Head and all trained staff of FCRC shall have a valid professional Annual Practising Certificate (APC), privileging and Good Clinical Practise (GCP) Certification for Intervention study and relevant certificate.		
		2. Appointment/assignment/placement letters		
		3. Experience of the head and staff meets the demands of their positions.		
		4. Deployment/assignment according to staff speciality.		
		5. Training and competency records		
	Facility Comments:			
26.2.1.2	The authority, responsibilities and accountabilities of the Head of FCRC are clearly delineated and documented.			
	EVIDENCE OF COMPLIANCE	1. Appointment/assignment letter and Term of Reference for Head of FCRC from relevant authority.		
		2. Description of duties and responsibilities.		
	Facility Comments:			
26.2.1.3	Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the need of the FCRC.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Number of staff and qualification commensurate with workload.				
		2. Staffing pattern				
		3. Duty roster				
		4. Census and statistics				
		Facility Comments:				
26.2.1.4	There are written and dated specific job descriptions for all categories of staff that include: a) qualifications, training, experience and certification required for the position; b) lines of authority; c) accountability, functions and responsibilities, d) reviewed when required and when there is a major change in any of the following: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations. e) administrative and clinical functions.					
	EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e).				
		2. Job description includes specialisation skills				
		3. Relevant privileges granted where applicable				
		4. The job description is acknowledged by the staff and signed by the Head of Service and dated.				
	Facility Comments:					
26.2.1.5	Personnel records on training, staff development, leave and others are maintained for every staff.					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	Note: Staff personal record may be kept in Human Resource Department as per Facility policy.					
	EVIDENCE OF COMPLIANCE	1. Staff personal records include:				
		a) staff biodata;				
		b) qualification and experience;				
		c) evidence of current registration;				
		d) training record;				
		e) competency record and privileging;				
		f) attendance and leave record;				
		g) confidentiality agreement.				
		i) deployment record outside hospital facility				
	Facility Comments:					
26.2.1.6	There is a structured orientation program where new staff are briefed on their services, operational policies, and relevant aspects of the Facility to prepare them for their roles and responsibilities.					
	EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation				
		2. Records on structured orientation programme				
		3. Orientation Brief				
		4. List of attendance				
	Facility Comments:					
26.2.1.7	There is evidence of training needs assessment and staff development plan which provides the knowledge and skills required for staff to maintain competency in their current positions and future advancement.					
	EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and gaps identified.				
		2. A staff development plan based on training needs assessment is available.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		3. Training schedule/calendar is in place.				
		4. Training module				
	Facility Comments:					
26.2.1.8	There are continuing education activities for staff including medical practitioner to pursue professional interests and to prepare for current and future changes in practice.					
	EVIDENCE OF COMPLIANCE	1. Training calendar includes in-house/external courses/workshop/conferences				
		2. Contents of training programme				
		3. Training records on continuing education activities are kept and maintained for each staff including training in life				
		4. Certificate of attendance/degree/post basic training.				
	Facility Comments:					
26.2.1.9	Staff receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.					
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff is completed upon probationary period and as an annual exercise.				
	Facility Comments:					
26.2.1.10	In a teaching Facility, the FCRC shall address the educational needs and provide teaching for undergraduates and postgraduates as determined by the Facility.					
	EVIDENCE OF COMPLIANCE	1. Record on mentoring and relevant research training for undergraduates and postgraduates as determined by the Facility.				
		2. Memorandum of Understanding				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
26.2.1.11	In Facilities which have teaching and research responsibilities, the staff of the FCRC give their cooperation or participate in the teaching and research programmes as determined by the Facility.				
	EVIDENCE OF COMPLIANCE	1. Documentation on participation in a teaching / research training/ mentoring as determined by the Facility.			
	Facility Comments:				
26.2.1.12	FCRC shall have arrangements for the: a) Promotion of staff well-being. b) Resolution of workplace issues.				
	EVIDENCE OF COMPLIANCE	1. Documented procedures to promote well-being, e.g. stress management, healthy lifestyle programmes			
		2. Documented procedure to manage workplace issues.			
		3. Staff being provided with appropriate supervision, support and advice			
	Facility Comments:				
26.2.1.13	FCRC shall educate and support patients/ service users utilising clinical research findings to maintain and improve their own health and wellbeing.				
	EVIDENCE OF COMPLIANCE	1. Documented communication between researcher and patient/subject on research findings (if applicable)			
		2. Assessment of patient medical condition			
		3. Referral to relevant party(ies) for further management			
		4. Training plan on person-centred care in clinical trial by FCRC			

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	Facility Comments:			

SURVEY ITEM & SELF-ASSESSMENT						
TOPIC 26.3:		POLICIES AND PROCEDURES				
STANDARD 26.3.1		There are documented policies and procedures that reflect current knowledge and practice for the FCRC and are consistent with goals and objectives of the FCRC and relevant regulations and statutory requirements.				
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
26.3.1.1 CORE	There are written policies and procedures for each of the services provided by FCRC which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated.					
	There is a mechanism for and evidence of a periodic review at least once in every three years.					
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for the service.				
		2. Policies and procedures are consistent with regulatory requirements and current standard practices such as International Council for Harmonisation of Technical Requirements for Pharmaceuticals for Human Use – Good Clinical Practice (ICH-GCP), Director General Circular on Conducting Research in Ministry of Health, Cosmetic and Drug Act, Medical Device Act, The Malaysian Code of Responsible Conduct in Research by National Science Council, Medical Research Ethics Committee (MREC), Malaysian Guidelines on the Use of Human Biological Samples for Research, Facility policies & procedures, and relevant regulations and guidelines.				
		3. Evidence of periodic review of policies and procedures.				
		4. The policies and procedures are endorsed and dated.				
	Facility Comments:					
26.3.1.2	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved.					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.				
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.			
		2. Minutes of meeting with evidence of cross reference with other departments, e.g.. Hospital Research Committee			
		3. Documented cross departmental policies			
	Facility Comments:				
26.3.1.3	Current policies and procedures are communicated to all staff.				
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings			
		2. Circulation list and acknowledgement			
	Facility Comments:				
26.3.1.4 CORE	There is evidence of compliance with policies and procedures.				
	EVIDENCE OF COMPLIANCE	1. Compliance with policies and procedures through:			
		a) interview of staff on practices;			
		b) verify with observation on practices;			
		c) results of audit on practices;			
		d) practices in line with established policies and procedures.			
	Facility Comments:				
26.3.1.5	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.				
	Facility Comments:					
26.3.1.6	The processes needed for the FCRC quality management, which are consistent with and are contributing towards the FCRC and Facility's goals and objectives shall be determined.					
	EVIDENCE OF COMPLIANCE	1. Adequate standard process sequence and interaction of the processes provided by the FCRC.				
	Facility Comments:					
26.3.1.7	There are written sequence and interaction of the processes provided by the FCRC.					
	EVIDENCE OF COMPLIANCE	1. Adequate documentation on sequence and interaction of the processes provided by the FCRC.				
	Facility Comments:					
26.3.1.8	Resources and information needed to support the monitoring and operation of these processes shall be made available.					
	EVIDENCE OF COMPLIANCE	1. Adequate resources and information to support the monitoring and operation of these processes shall be made available.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT				
TOPIC 26.4:	<u>FACILITIES AND EQUIPMENT</u>			
STANDARD 26.4.1	<i>Adequate facilities and equipment are available to enable the FCRC to meet its goals and objectives.</i>			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT
				SURVEYOR RATING
26.4.1.1	There are adequate and appropriate facilities and equipment with proper utilisation of space to enable staff to carry out their professional and administrative functions.			
	EVIDENCE OF COMPLIANCE	1. Adequate and proper utilisation of space.		
		2. Appropriate type of equipment to match the complexity of services.		
		3. Easy access and clear exit routes.		
	Facility Comments:			
26.4.1.2	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.			
	EVIDENCE OF COMPLIANCE	1. Testing, commissioning and calibration records (certificates or stickers)		
		2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as evidence of compliance to the relevant standards and Acts.		
	Facility Comments:			
26.4.1.3 CORE	There is evidence that the Facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	EVIDENCE OF COMPLIANCE	1. Planned Preventive Maintenance records such as schedule, stickers, etc.					
		2. Planned Replacement Programme where applicable					
		3. Complaint records					
		4. Asset inventory					
	Facility Comments:						
26.4.1.4	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.						
	EVIDENCE OF COMPLIANCE	1. User training records					
		2. Competency assessment record					
		3. Letter of authorisation					
		4. List of staff trained and authorised to operate specialised equipment					
	Facility Comments:						

SURVEY ITEM & SELF-ASSESSMENT							
TOPIC 26.5: SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES							
STANDARD 26.5.1 <i>The FCRC is required to be involved in the Facility's performance improvement activities as per determined by the respective quality departments of the Facility. These performance improvements activities will be consistent with the quality objectives of the FCRC towards contributing to the quality objectives of the Facility.</i>							
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS				
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING			
26.5.1.1	The FCRC required to conduct risk assessment that could be relevant to patients/service users and/or staff base on: a) Identify procedures, treatments or aspects of care that are at risk; i. Procedures in research and clinical trials ii. Laboratory activities in FCRC iii. Risks of Investigational product (IP) or medical devices incident (if applicable) iv. Risk of research misconduct involving individual or team The FCRC shall have appropriate mitigation plan for the risks determine by the Facility.						
	EVIDENCE OF COMPLIANCE				1. Documented policies and procedures for risk assessment plan		
					2. Structured mitigation plans which include:		
					a) Training of staffs		
					b) Policy and procedure		
					c) Reports		
					d) Acknowledgement by Head of Service and PIC/Hospital Director		
	e) Feedback given						
	Facility Comments						

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
26.5.1.2	Procedures in research and clinical trials, these could include (if applicable to FCRC): a) Genetic and genomic testing b) Medical and healthcare device eg: robotics device, 3D, applications and etc c) Equipment and procedure risks, e.g. fire/injury, sharp injuries and etc d) Research recruitment strategy e) Unauthorized personnel to perform research related activities f) Unreliable research data			
	EVIDENCE OF COMPLIANCE			
	1. Documented policies and procedures for risk assessment plan			
	2. Structured mitigation plans which include:			
	a) Training of staffs			
	b) Policy and procedures			
	c) Evidence of delegation log			
	d) Documented data management strategies e.g: quality assurance and quality control			
	e) Reports			
	f) Acknowledgement by Head of Service and PIC/Hospital Director			
	g) Feedback given			
	Facility Comments:			
26.5.1.3	Risk of chemical hazard, biological hazard, physical hazard of FCRC with laboratory facilities, these could relate to (if applicable)			
	EVIDENCE OF COMPLIANCE			
	1. Documented policies and procedures for risk assessment plan			
	2. Mitigation plan for laboratory activities in FCRC which include:			
	a) Training of staffs			
	b) Policy and procedures			
	c) Reports			
	d) Acknowledgement by Head of Service and PIC/Hospital Director			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		e) Feedback given				
		Facility Comments:				
26.5.1.4		Risks of incident involving Investigational product (IP) or medical devices (MD) (if applicable): a) Discoloration b) Broken/malfunction c) Others				
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for risk assessment plan				
		2. Mitigation plan for risks IP or MD which include:				
		a) Training of staffs				
		b) Policy and procedure in place for transportation, storage dispensing, accountability and destruction of IP or MD				
		c) Reports				
		d) Acknowledgement by Head of Service and PIC/Hospital Director				
		e) Feedback given				
		Facility Comments:				
26.5.1.1		The Head of the FCRC shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility. Incidents reported have had Root Cause Analysis done and action taken within the agreed timeframe to prevent recurrence.				
	EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:				
		a) Training of staff				
		b) Policy on incident reporting				
		c) Methodology of incident reporting				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		d) Register/records of incidents				
		2. Completed incident reports				
		3. Root Cause Analysis				
		4. Corrective and preventive action plans				
		5. Remedial measure				
		6. Minutes of meetings				
		7. Acknowledgment by Head of Service and PIC/Hospital Director				
		8. Feedback given to staff regarding incident reporting.				
		Facility Comments:				
26.5.1.2		The FCRC shall oblige to any quality audit processes from either the Facility or relevant regulatory or certifying bodies.				
	EVIDENCE OF COMPLIANCE	1. FCRC obliges to any quality audit processes from either the Facility or relevant regulatory or certifying bodies by providing audit reports and Corrective Action Preventive Action (CAPA) report.				
		Facility Comments:				
26.5.1.3		There shall be participation from among FCRC staff in the monitoring and audit processes of the Facility.				
	EVIDENCE OF COMPLIANCE	1. Evidence of participation among FCRC staff in the monitoring and audit process of the Facility.				
		Facility Comments:				
26.5.1.4		The Head of FCRC ensures necessary actions shall be implemented to achieve planned results in line with the FCRC quality objectives.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Relevant records on implementation of actions taken evidenced on-site.				
	Facility Comments:					
26.5.1.5	Whenever relevant the quality procedures shall be reviewed by the FCRC management in the interest of improvements to the Facility and FCRC quality systems.					
	EVIDENCE OF COMPLIANCE	1. Adequate records on reviews and amendments by the FCRC management in the interest of improvements to the facility's and FCRC quality systems.				
	Facility Comments:					
26.5.1.6 CORE	There is tracking and trending of specific performance indicators not limited to but at least two (2) of the following: a) number of training conducted per year (Target : minimum of 2 per year) b) number of publications per year (Target : minimum 2 per year)					
	EVIDENCE OF COMPLIANCE	1. Written document for performance improvement activities				
		2. Assigned individual / committee for performance improvement activities				
		3. Records on safety and performance improvement activities.				
		4. Records on training conducted or part of organizing committee per year, e.g. Good Clinical Practise (GCP), Introduction to Clinical Research (ICR) and etc.				
		5. Records on Hospital/Facility Publication per year.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
26.5.1.7	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.							
	EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff.						
		2. Evidence of feedback via communication on results of performance improvement activities through continuing education activities/meetings.						
		3. Minutes of service/unit/committee meetings						
	Facility Comments:							
26.5.1.8	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.							
	EVIDENCE OF COMPLIANCE	1. Documentation on performance improvement activities and performance indicators.						
		2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						
	Facility Comments:							
26.5.1.13	FCRC shall follow the emergency/ disaster recovery plan by Facility. The disaster could be natural (e.g. floods, earthquakes, hurricanes, disease outbreaks), or manmade (e.g. urban fires, industrial accidents, bioterrorism). The disaster recovery plan may also be referred to as an emergency or contingency plan.							
	EVIDENCE OF COMPLIANCE	1. Documentation on Emergency / Contingency Plan						
		2. Documented of FCRC staff responsibilities during emergency/disaster						
	Facility Comments:							

SURVEY ITEM & SELF-ASSESSMENT							
<u>TOPIC 26.6:</u>	<u>SPECIAL REQUIREMENTS</u>						
<u>STANDARD</u> <u>26.6.1</u>	<i>Research (Industrial Sponsored Research, ISR) or Investigator Initiated Research (IIR)</i>						
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
26.6.1.1 CORE	There is a Facility Research Review Committee for reviewing minimal risk research protocol (IIR).						
	EVIDENCE OF COMPLIANCE	1. Medical Research Ethics Committee/ Institutional Review Board / Independent Ethics Committee for research involve human subject.					
		2. Minutes of meetings of the above committee					
		3. Adequate documentation on protocol to review activities in hard copy/soft copy as required by Ethics Committee.					
	Facility Comments:						
26.6.1.2 CORE	The research (Industrial Sponsored Research, ISR) or Investigator Initiated Research (IIR) shall obtain approval from relevant authority.						
	EVIDENCE OF COMPLIANCE	1. Adequate documentation in hard copy/ soft copy on approval from relevant authority.					
	Facility Comments:						

SURVEY ITEM & SELF-ASSESSMENT						
SERVICE STANDARD 27 : STANDARDS FOR DECEASED ORGAN AND TISSUE DONATION AND PROMOTION						
	<u>PREAMBLE</u> <i>Deceased organ and tissue donation service shall include donor identification, management of potential donors including family approaches for organ and tissue donation, coordination, and procurement management to enable access to transplantation for patients who are suffering from end stage organ failure or in the need of tissue replacement.</i> <i>Promotional activity in this service is responsible for the education of both healthcare professionals and the public in organ and tissue donation.</i> <i>This service is part of a multidisciplinary team for the transplantation activity in this country.</i>					
<u>TOPIC 27.1:</u> <u>STANDARD 27.1.1</u>	<u>ORGANISATION AND MANAGEMENT</u> <i>The deceased organ and tissue donation services shall be organised and administered by trained and qualified donor coordinators to provide services to family members of the deceased ethically, responsibly and with competence and integrity. This service shall be coordinated with other relevant clinical services</i>					
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
27.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the department are clearly documented and measurable. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body.				
		2. Goals and objectives of the Services in line with the Facility statements are available, endorsed and dated.				
		3. Evidence of planned reviews of the above statements.				
		4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	5. Achievement of goals and objectives are monitored, Reviewed and revised accordingly.					
	Facility Comments:					
27.1.1.2 CORE	There is an organisation chart which: a) provides a clear representation of the structure, functions and reporting relationships between the Person in Charge (PIC), Head and staff of the Service; b) is accessible to all staff and clients; c) includes off-site services if clients; d) is revised when there is a major change in any of the following: - i). Organisation; - ii). Functions; - iii). Reporting relationships; - iv). Staffing patterns.					
	EVIDENCE OF COMPLIANCE	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head and staff of the Service.				
		2. Organisation chart of the service is endorsed, dated and accessible.				
		3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).				
	Facility Comments:					
27.1.1.3	Regular staff meetings are held between the Head of department, staff and Head of Institution, with sufficient regularity to discuss issues and matters pertaining to the operations of the service. Minutes are kept; decision and resolution made during meetings shall be accessible, communicated to all staff of the service and implemented.					
	EVIDENCE OF COMPLIANCE	1. Minutes are accessible, disseminated and acknowledged by the staff.				
		2. Attendance list of members with adequate representatives of the service.				
		3. Frequency of meetings as scheduled.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
		4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).				
	Facility Comments:					
27.1.1.4	The Head of department is involved in the planning, justification and management of the budget and resource utilisation of the services.					
	EVIDENCE OF COMPLIANCE	1. Minutes of Facility-wide management meeting				
		2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service.				
		3. Approved budget and resources.				
	Facility Comments:					
27.1.1.5	The Head of Department is involved in the appointment and/OR assignment of staff.					
	EVIDENCE OF COMPLIANCE	1. Records on staff interview				
		2. Appointment/assignment letter of Head of Service				
		3. Job description of Head of Service				
		4. Records on staff deployment				
		5. Duty roster				
	Facility Comments:					
27.1.1.6	Appropriate statistics and records shall be maintained in relation to the provision of Service and used for managing the services and patient care purpose.					
	EVIDENCE OF COMPLIANCE	1. Records are available but not limited to the following:				
		a) workload/census;				
		b) annual report;				
		c) accident/incident reports;				
		d) staffing number and staff profile;				
		e) staff training records;				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	f) data on performance improvement activities, including performance indicators.					
	Facility Comments:					
27.1.1.7	Notation in the National Transplant Procurement Management Unit (NTPMU) referral form and donor's medical record that the following activity was carried out: a) Identification b) Referral to National Transplant Centre c) Family approach for donation d) Procurement activity					
	EVIDENCE OF COMPLIANCE	1. Records are signed, dated and designation stated				
	Facility Comments:					
27.1.1.8	Where services are provided from an external source there is a written agreement between the external service provider and the Facility stating the requirements for service delivery, including the following, where applicable: a) Formal lines of communication and responsibilities between the external service provider and the Facility b) Provision of adequate numbers of appropriately qualified personnel to perform their duties. c) Participation, as appropriate, of the external service provider in committees of the Facility; d) Arrangement for adequate pickup and delivery e) Arrangements for after hours and emergency services f) Mechanisms in dealing with problems in service delivery g) Adequate facilities and equipment for providing the services at the Facility and at the site of the external service; h) Involvement of the external service provider in safety and performance improvement activities of the Facility, as appropriate;					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	i) Comply with the appropriate MSQH Standards of Accreditation for that part of the service which functions within the Facility.					
	EVIDENCE OF COMPLIANCE	1. Written agreement which include (a) to (i) between the external service provider and the Facility is endorsed, signed and dated.				
	Facility Comments:					

SURVEY ITEM &SELF-ASSESSMENT							
TOPIC 27.2		HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT					
STANDARD 27.2.1		This service shall be directed by a person qualified in donation and transplantation and assisted by adequately qualified and experienced staff to ensure deceased organ and tissue donation is practiced according to its objectives and ensure continuing education and professional development of its staff.					
	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
27.2.1.1	The Head and staff of the Service shall be individuals qualified by education, training, experience and certification to commensurate with the requirements of the various positions.						
	EVIDENCE OF COMPLIANCE	1. Records on credentials of Head of Service and staff required to fill up the posts within the service (to match the complexity of the Facility and services) and certification/registration.					
		2. Appointment/assignment letters					
		3. Certification					
		4. Training and competency records					
	Facility Comments:						
27.2.1.2	The authority, responsibilities and accountabilities of the Head of Services are clearly delineated and documented.						
	EVIDENCE OF COMPLIANCE	1. Appointment/assignment letter for Head of Service.					
		2. Description of duties and responsibilities.					
	Facility Comments:						
27.2.1.3	Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the need of the services.						

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Number of staff and qualification should commensurate with workload.				
		2. Staffing pattern				
		3. Duty roster				
		4. Census and statistics				
		Facility Comments:				
27.2.1.4	There are written and dated specific job descriptions for all categories of staff that include: a) qualifications, training, experience and certification required for the position; b) lines of authority; c) accountability, functions and responsibilities; d) reviewed when required and when there is a major change in any of the following: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations. e) administrative and clinical functions.					
	EVIDENCE OF COMPLIANCE	1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e).				
		2. Job description includes specialisation skills				
		3. Relevant privileges granted where applicable				
		4. The job description is acknowledged by the staff and signed by the Head of Service and dated.				
	Facility Comments:					
27.2.1.5	Personnel records on training, staff development, leave and others are maintained for every staff.					

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	Note: Staff personal record may be kept in Human Resource Department as per Facility policy.					
	EVIDENCE OF COMPLIANCE	1. Staff personal records include:				
		a) staff biodata;				
		b) qualification and experience;				
		c) training record;				
		d) competency record and privileging;				
		e) leave record;				
		f) confidentiality agreement.				
	Facility Comments:					
27.2.1.6	There is a structured orientation programme where new staff are briefed on their services, operational policies and relevant aspects of the Facility to prepare them for their roles and responsibilities.					
	EVIDENCE OF COMPLIANCE	1. Policy requiring all new staff to attend a structured orientation programme.				
		2. Records on structured orientation programme				
		3. Orientation Brief				
		4. List of attendance				
	Facility Comments:					
27.2.1.7	There is evidence of training needs assessment and staff development plan which provides the knowledge and skills required for staff to maintain competency in their current positions and future advancement.					
	EVIDENCE OF COMPLIANCE	1. Training needs assessment is carried out and gaps identified.				
		2. A staff development plan based on training needs assessment is available.				
		3. Training schedule/calendar is in place.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	4. Training module					
	Facility Comments:					
27.2.1.8	There are continuing education activities for staff including medical practitioner to pursue professional interests and to prepare for current and future changes in practice.					
	EVIDENCE OF COMPLIANCE	1. Training calendar includes in-house/external courses/workshop/conferences				
		2. Contents of training programme				
		3. Training records on continuing education activities are kept and maintained for each staff including training in life support.				
		4. Certificate of attendance/degree/post basic training.				
	Facility Comments:					
27.2.1.9	Staff receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.					
	EVIDENCE OF COMPLIANCE	1. Performance appraisal for staff is completed upon probationary period and as an annual exercise.				
	Facility Comments:					
27.2.1.10	In a teaching hospital, the Service shall provide educational needs and teaching for undergraduates and postgraduates without compromising patient safety and comfort.					
	EVIDENCE OF COMPLIANCE	1. Sufficient skilled and trained staff to provide clinical supervision				
		2. Memorandum of Understanding.				
	Facility Comments:					

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
27.2.1.11	In Facilities which have teaching and research responsibilities, the staff of the Service give their cooperation or participate in the teaching and research programmes.				
	EVIDENCE OF COMPLIANCE	1. Letter of appointment – Local Preceptor/ Clinical Instructor			
		2. Qualification and training records of local preceptor.			
	Facility Comments:				

SURVEY ITEM &SELF-ASSESSMENT					
TOPIC 27.3:		<u>POLICIES AND PROCEDURES</u>			
STANDARD 27.3.1		<i>Deceased organ and tissue donation is practiced according to the National Organ, Tissue and Cell Transplantation Policy (2007). This policy states the relevant regulations and reflect the goals and objectives of the deceased organ and tissue donation and promotion in the country.</i>			
	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS		
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
27.3.1.1 CORE	There are written policies and procedures for the Service which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated.				
	There is a mechanism for and evidence of a periodic review at least once in every three years.				
	EVIDENCE OF COMPLIANCE	1. Documented policies and procedures for the service.			
		2. Policies and procedures are consistent with regulatory requirements and current standard practices.			
		3. Evidence of periodic review of policies and procedures.			
		4. The policies and procedures are endorsed and dated.			
Facility Comments:					
27.3.1.2	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved. Cross departmental collaboration is practised in developing relevant policies and procedures where applicable				
	EVIDENCE OF COMPLIANCE	1. Minutes of committee meetings on development and revision on policies and procedures.			
		2. Minutes of meeting with evidence of cross reference with other departments			
		3. Documented cross departmental policies			
		Facility Comments:			

	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
27.3.1.3	Current policies and procedures are communicated to all staff.					
	EVIDENCE OF COMPLIANCE	1. Training and briefing on the current policies and procedures/Minutes of meetings				
		2. Circulation list and acknowledgement				
	Facility Comments:					
27.3.1.4 CORE	There is evidence of compliance with policies and procedures.					
	EVIDENCE OF COMPLIANCE	1. Compliance with policies and procedures through:				
		a) interview of staff on practices;				
		b) verify with observation on practices;				
		c) results of audit on practices;				
		d) practices in line with established policies and procedures.				
	Facility Comments:					
27.3.1.5	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.					
	EVIDENCE OF COMPLIANCE	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.				
	Facility Comments:					

SURVEY ITEM & SELF-ASSESSMENT				
TOPIC 27.4:	<u>FACILITIES AND EQUIPMENT</u>			
STANDARD 27.4.1	<i>Appropriate, adequate and safe facilities and equipment are available to enable deceased organ and tissue donation and promotion meets its objectives and goals.</i>			
	CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT
				SURVEYOR RATING
27.4.1.1	There are adequate and appropriate facilities and equipment with proper utilisation of space to enable staff to carry out their professional and administrative functions.			
	EVIDENCE OF COMPLIANCE	1. Adequate and proper utilisation of space.		
		2. Appropriate type of equipment to match the complexity of services.		
		3. Easy access and clear exit routes		
		4. Absence of overcrowding		
	Facility Comments:			
27.4.1.2	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.			
	EVIDENCE OF COMPLIANCE	1. Testing, commissioning and calibration records (certificates or stickers)		
		2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as evidence of compliance to the relevant standards and Acts.		
	Facility Comments:			
27.4.1.3 CORE	There is evidence that the Facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.			

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING	
	EVIDENCE OF COMPLIANCE	1. Planned Preventive Maintenance records such as schedule, stickers, etc.					
		2. Planned Replacement Programme where applicable					
		3. Complaint records					
		4. Asset inventory					
	Facility Comments:						
27.4.1.4	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.						
	EVIDENCE OF COMPLIANCE	1. User training records					
		2. Competency assessment record					
		3. Letter of authorisation					
		4. List of staff trained and authorised to operate specialised equipment					
	Facility Comments:						

SURVEY ITEM &SELF-ASSESSMENT						
<u>TOPIC 27.5:</u>		<u>SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES</u>				
<u>STANDARD 27.5.1</u>		<i>The head of the deceased organ and tissue donation shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the service..</i>				
		CRITERIA FOR COMPLIANCE:		SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
27.5.1.1		There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Service. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.				
EVIDENCE OF COMPLIANCE	1. Planned performance improvement activities include (a) to (f)					
	2. Records on performance improvement activities.					
	3. Minutes of performance improvement meetings					
	4. Performance improvement studies					
	5. Records on innovation if available					
Facility Comments:						
27.5.1.2		The Head of Service has assigned the responsibilities for planning, monitoring and managing safety and performance improvement to appropriate individual / personnel within the respective services.				

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS	
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	EVIDENCE OF COMPLIANCE	1. Minutes of meetings				
		2. Letter of assignment of responsibilities				
		3. Terms of Reference/Job description				
	Facility Comments:					
27.5.1.3	EVIDENCE OF COMPLIANCE	1. System for incident reporting is in place, which include:				
		a) Training of staff				
		b) Policy on incident reporting				
		c) Methodology of incident reporting				
		d) Register/records of incidents				
		2. Completed incident reports				
		3. Root Cause Analysis				
		4. Corrective and preventive action plans				
		5. Remedial measure				
		6. Minutes of meetings				
		7. Acknowledgment by Head of Service and PIC/Hospital Director				
		8. Feedback given to staff regarding incident reporting.				
		Facility Comments:				
27.5.1.4 CORE	Tracking and trending of the following performance indicator:					
	1. Percentage of potential donors (≥2%)					
	2. Update of newly registered organ and tissue donor pledger into National					

	CRITERIA FOR COMPLIANCE:			SELF RATING	SURVEYOR FINDINGS			
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING		
	Transplant Resource Center (NTRC) database within 3 days (≥70%)							
	EVIDENCE OF COMPLIANCE	1. Specific performance indicators monitored.						
		2. Records on tracking and trending analysis.						
		3. Remedial measures taken where appropriate.						
	Facility Comments:							
27.5.1.5	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.							
	EVIDENCE OF COMPLIANCE	1. Results on safety and performance improvement activities are accessible to staff.						
		2. Evidence of feedback via communication on results of performance improvement activities through continuing education activities/meetings.						
		3. Minutes of service meetings						
	Facility Comments:							
27.5.1.6	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.							
	EVIDENCE OF COMPLIANCE	1. Documentation on performance improvement activities and performance indicators.						
		2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						
	Facility Comments:							

SERVICE SUMMARY	
SURVEYOR SUMMARY:	
OVERALL RATING:	
OVERALL RISK:	