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SERVICE STANDARD 01 : GOVERNANCE, LEADERSHIP AND DIRECTION

PREAMBLE

Each Facility shall have a body ultimately responsible for all aspects of the Facility's operations. This is commonly called the Board of Directors or any other names with similar responsibility/function such as the State Health Department and Medical Development Division. 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), who shall be responsible for the organisation, management, and control of the Healthcare Facility and Services as required under the Statutory Requirement as stipulated in the Appendix.

All healthcare facilities shall possess an approved document from the relevant ministries; this document shall detail all services rendered by each Facility.

The Governing Body shall demonstrate visible and sustained leadership in shaping a culture of quality, safety, sustainability and resilience throughout the organisation. This includes establishing a clear strategic direction and governance mechanism for Business Continuity Management (BCM) to protect critical hospital and institutional functions and ensure continuity of care during adverse events. The Governing Body is accountable for fostering a just culture of psychological safety, equity, and continuous learning including emerging strategic risks, including digital transformation, cybersecurity, and environmental sustainability, ensuring the organization's resilience and ethical alignment with community needs.

TOPIC 1.1
ORGANISATION AND MANAGEMENT

STANDARD 1.1.1

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.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of critical nursing services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 1.1.1.1							
The Governing Body shall ensure that the Vision, Mission and value statements, strategic goals, and operational plan objectives are	1. Vision, Mission and values statements, goals, and objectives of the Facility are available; endorsed, and dated by the Governing Body;						

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informed by assessments of clinical, operational, financial, cyber, and environmental sustainability risks. They shall be clearly documented, measurable, and reviewed at least once every 4 years and when required to reflect the evolving internal and external landscape. Strategic goals must include specific aims related to health equity, patient safety culture, and environmental stewardship. The Governing Body through the Person in Charge (PIC) shall measure the progress towards achieving the objectives as this reflects 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.	2. Evidence of planned reviews of the above statements; 3. These statements are communicated to all staff (orientation programme, minutes of meeting, etc); and 4. Achievement of goals, and objectives is monitored, reviewed, and revised accordingly.						
CRITERION 1.1.1.2							
The Governing Body shall ensure a structured, ongoing process to understand and address the needs of the community served, including vulnerable and underserved populations. This shall inform service planning and policies. The Facility shall establish and utilize a multi-stakeholder committee (e.g., Board of Visitor) that includes patient/family representatives, community leaders, and public	1. *Establishment of Board of Visitors; 2. Agenda and minutes of meetings are accessible, with actions taken, followed-up, disseminated, and acknowledged by the members of the committee; 3. Policy on Patient and Family Rights; and 4. Patient's charter.						

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health partners to provide input on strategic priorities, service design, and policies such as Patient and Family Rights.							
CRITERION 1.1.1.3 (CORE)							
The Governing Body shall adopt a governing framework in accordance with statutory and other legal requirements.	1. License to operate (Private Healthcare Facility) or Gazettement letters and/or supporting documents (Public Healthcare Facility);						
	2. *Appointment of a full time PIC who is qualified, trained and experienced;						
	3. Facility-wide and Departmental/Service Operational Policies; and						
	4. Medical Staff By-Laws or equivalent.						
CRITERION 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 shall include 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;	1. Updated 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 (TOR) of committees;						

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iii) is revised when there is a major change in the organisation plan, functions, reporting relationships, goals and objectives, and staffing patterns; and iv) shall be exhibited in a conspicuous part of the Facility. b) appointment of members of the Governing Body, its officers including 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. The authority and duties of the Governing Body, its officers and committees shall also be documented. c) relationship of the Governing Body, PIC and other executive staff; and the structure of reporting relationship of the services, medical practitioners, nursing staff, and all other allied healthcare professionals shall be indicated. d) the governing framework shall be reviewed at regular intervals and the governing framework shall be made	6. Agenda and minutes of Facility-wide Management Committee meetings are accessible, with actions taken, followed-up, disseminated, and acknowledged by members of the Committee;						
	7. Agenda and minutes of Board meetings are accessible, with actions taken, followed-up, disseminated, and acknowledged by Board members; and						
	8. Evidence of review of the following documents (at least once every three years or earlier if needed):						
	a. Facility-wide Operational Policies;						
	b. Departmental/Service Operational Policies;						
	c. Medical Staff By-Laws or equivalent;						
	d. TOR of committees; and						
	e. Above documents are made accessible to all members of the Committee/Board. (hard or soft copies).						

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accessible to staff of the Facility.							
CRITERION 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, Malaysian Civil Defence Force (APM), and others.	1. Memorandum of Understanding and TOR with the voluntary/auxiliary organisations.						
CRITERION 1.1.1.6							
The Governing Body shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	1. Documented and approved BCP for emergency services;						
	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. likelihood; b. impact; c. assigned ownership, and d. risk treatment.						
	3. Clear actions and staff responsibilities during disruption;						
	4. Record of drills or tests, with follow-up actions; and						
	5. Review of Risk Register.						

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STANDARD 1.1.2

There shall be an appointment of the PIC who shall be a person possessing such qualification, training, and experience as prescribed by statute. The PIC shall be responsible for the organisation, management, and control of the Healthcare Facility or Services to which a licence or certificate of registration relates to and he or she 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 or their equivalent.

There shall be a Medical Advisory Committee (MAC) or Medical and Dental Advisory Committee (MDAC) or equivalent which shall advise the Governing Body to plan, coordinate, implement, control, and improve all activities relating to clinical governance.

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CRITERION 1.1.2.1							
The PIC or Hospital Director shall hold a degree in medicine, registered with the Malaysian Medical Council (MMC), and has appropriate training and experience. The authority, responsibilities and accountability of the PIC shall be clearly delineated and documented in a letter of appointment.	1. Appointment letter of the PIC;						
	2. Job description of the PIC/Hospital Director;						
	3. Resume of PIC/Hospital Director; and						
	4. Training certificate pertaining to hospital management.						
CRITERION 1.1.2.2							
The PIC or Hospital Director shall be responsible for establishing an organisational structure that clearly represents the uniformity of the clinical services and reporting relationships. Where there are two or more registered medical practitioners or registered dental practitioners in any one specialty in the Facility, separate designated heads and functional	1. Organisation charts of clinical services by departments/functional units with clear evidence of line of reporting;						
	2. Departmental/Functional Unit meetings conducted as per TOR; and						
	3. Agenda and minutes of meetings of department/functional units shall be approved by the HOD and are accessible, with actions taken, followed-up, disseminated, and						

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units/services shall be established for effective delivery of clinical services.	acknowledged by relevant members.						
CRITERION 1.1.2.3							
The Governing Body through the PIC, where applicable, shall establish the following policies and procedures for medical practitioners and other healthcare professionals: a) appointment; b) reappointment; and c) delineation of clinical privileges and re-privileging process, roles and responsibilities.	1. Policies and procedures on:						
	a. Appointment and reappointment; and						
	b. Credentialing and privileging and re-privileging processes.						
	2. Agenda and minutes of the Credentialing and Privileging Committee are accessible, with actions taken, followed-up, disseminated, and acknowledged by relevant members;						
	3. Certified privileging certificates, with serial number; and						
	4. Roles and responsibilities for medical practitioners, consultants, and other healthcare professionals.						
CRITERION 1.1.2.4 (CORE)							
The Management Committee or 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 members of the Facility and to the Governing Body.	1. List of members of the Management Committee or equivalent;						
	2. Evidence that members of the Management Committee or equivalent represent the various respective departments;						
	3. Letter of appointment;						
	4. TOR of Committee; and						

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	5. Agenda and minutes of meetings of the Management Committee are accessible, with actions taken, followed up, disseminated, and acknowledged by members of the Committee.						
CRITERION 1.1.2.5 (CORE)							
The PIC or Hospital Director of the Facility shall establish a MAC or in the presence of one or more registered dental practitioners, a MDAC whose members shall be registered medical practitioners and registered dental practitioners representing all registered medical practitioners and registered dental practitioners practising in the Facility. The MAC or MDAC shall advise the Governing Body and PIC on all aspects relating to medical and dental practices.	1. Establishment of MAC/MDAC or equivalent;						
	2. Appointment letter of members of MAC/MDAC or equivalent;						
	3. Terms of Reference of MAC/MDAC or equivalent;						
	4. MAC/MDAC or equivalent meetings conducted as per TOR; and						
	5. Agenda and minutes of meetings are accessible, with actions taken, followed-up, disseminated, and acknowledged by relevant members.						
CRITERION 1.1.2.6							
The MAC/MDAC or equivalent 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 and re-privileging of clinical care providers;	1. List of standing agenda in MAC/MDAC or equivalent meeting (if no subcommittees)/subcommittees to address (a) to (j);						
	2. Membership of subcommittees (if applicable 2 to 5);						
	3. Appointment letter of members of subcommittees;						
	4. TOR of subcommittees; and						

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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; f) Prevention and control of infection and antibiotic usage; g) Drug utilisation and medication practices; h) Use of blood and blood products; and i) Continuing professional development (CPD), training, and continuing medical education (CME); and j) Facilitation and supervision of research including the ethical aspects of research, where appropriate. The PIC or Hospital Director shall ensure that relevant clinical core committees are established either as committee chaired by PIC/hospital director/clinician or subcommittee of MDAC/MAC to ensure good governance of clinical services. The committee shall address at least the following areas of concern:	5. Agenda and minutes of meetings of subcommittees are accessible, with actions taken, followed-up, disseminated and acknowledged by members of the Committee.				-		

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a) Development and consensus of policies, procedures, and standards of patient care evidence-based guidelines; b) Credentialing and privileging and re-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; f) Prevention and control of infection and antibiotic usage; g) Drug utilisation and medication practices; h) Use of blood and blood products; and i) Continuing professional development (CPD), training, and continuing medical education (CME)							

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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.

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CRITERION 1.1.3.1							
The Governing Body through the PIC or Hospital Director and Management Team shall be responsible for the efficient, ethical and sustainable management of the resources of the Facility.	1. Service management reflected in job descriptions of the PIC and Management Team (Heads of Services), where applicable;						
	2. Agenda and minutes of financial and management meetings are accessible, with actions taken, followed-up, disseminated and, acknowledged by relevant members;						
	3. Financial management report;						
	4. Auditor's report (internal and external); and						
	5. Annual budget report.						
CRITERION 1.1.3.2							
An external audit is carried out by an appropriately qualified independent auditor at least on an annual basis (for private Facility) or periodically (for public Facility), and is reported to the Governing Body or its representative.	1. Credentials of the external auditor; and						
	2. External auditor's report (private) or internal audit report (public).						

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CRITERION 1.1.3.3							
The Governing Body or its representative (such as the Board of Management) shall regularly review the audit reports and necessary action(s) shall be taken on any recommendations made by the auditor.	1. External auditor's report (private) or internal audit report (public);						
	2. Agenda and minutes of the Governing Body or Board of Management are accessible, with actions taken, disseminated, and acknowledged by the members of the Body/Board; and						
	3. Actions taken on auditor's recommendations and documented.						
CRITERION 1.1.3.4							
There is an appropriate programme of internal financial control.	1. Financial Standard Operating Procedures or Treasury Instruction/Circular; and						
	2. System for internal financial control.						
CRITERION 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.	1. Internal accounting system; and						
	2. Current financial report.						
CRITERION 1.1.3.6							
There are written policies and procedures for all accounting functions.	1. Documented policies and procedures for all accounting functions.						

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CRITERION 1.1.3.7							
There is an appropriate and effective system of asset, inventory and stock control.	1. System for inventory including but not limited to the following:						
	a. Stock taking;						
	b. Registry of inventory; and						
	c. Stock cards.						
	2. Receipt and distribution of assets;						
	3. Disposal of assets;						
	4. Monitoring of expired stock; and						
	5. Monitoring of equipment utilisation.						
CRITERION 1.1.3.8							
A budget shall be developed in consideration towards sustainability programmes with the participation of appropriate staff. Periodic reports showing the relationship between the budget and actual expenditure shall be produced and analysed. It should include dedicated budgeting for quality improvement initiatives, staff safety and wellbeing programmes, and technology that enhances patient care.	1. Mechanism for budget preparation;						
	2. Budget proposals, taking into consideration responsible use of resources and in support of sustainability programs;						
	3. Capital expenditure (CAPEX) or Operational expenditure (OPEX); and						
	4. Budget monitoring report (Analysis on budget versus expenditure).						

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CRITERION 1.1.3.9							
There is an insurance programme for the protection of the relevant staff members, the buildings, contents, and other physical assets. a) The protection of the assets; and b) Professional liability to protect the Facility in respect of the professional actions of medical practitioners, paramedics, and other support services staff.	1. Insurance policy certificate with details on covers for (a) to (b).						
CRITERION 1.1.3.10							
The Governing Body shall establish an integrated information and communication technology (ICT) strategy, structure, and system that shall include the following: a) Organisational structure clearly shows lines of communication, interaction, and decision making; and 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 organisation, where applicable.	1. Organisational chart especially showing clear clinical lines of communication, interaction, and decision making;						
	2. Clinical policies and procedures on the use of ICT, cybersecurity and other related services;						
	3. Patient records management system using electronic medical records (EMR) including completeness and quality of content of medical records; and						
	4. Information and communication technologies and tools including PABX, Pagers, Phones, social media, etc.						

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STANDARD 1.1.4

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.

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CRITERION 1.1.4.1							
The Governing Body shall ensure that all reasonable actions shall be taken to conform to all applicable government Statutes, Acts, Regulations, By-Laws, Ordinances, and Orders.	1. Copies of all relevant Acts, Regulations, By-Laws, Ordinances, and Orders related to the services are available (hardcopies or softcopies or both) 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; and						
	4. Full Incident Reporting Cycle related to non-conformance to relevant Acts, and Regulations, if any.						

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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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CRITERION 1.1.5.1 (CORE)							
There shall be 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; and b) There is documentation on the external aspects of the services which refers 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	1. List of all outsource services (clinical, non-clinicals, and clinical support);						
	2. Service contracts have appropriate terms and conditions as in (a) and (b) including the following:						

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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; and ix) personnel provided by the external services who shall be bound by the rules and regulations applicable to the staff of the Facility.	a. Date and duration of contract;						
	b. System for quality control ofoutsourced services (visit to off- site services, recognised certification);						
	c. Procedures for managing shortfall in service; and						

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	d. Involvement in performance measurement of the relevant services provided to the Facility.						

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TOPIC 1.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD 1.2.1
The Governing Body shall make adequate provision for the delegation of authority to the PIC/Hospital Director to ensure the achievement of the Facility's Vision, Mission, values, goals, and objectives.

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CRITERION 1.2.1.1							
The PIC or Hospital Director shall act in accordance with the policies, delegated authority and instructions of the Governing Body; and shall be responsible for the organisation, management, and control of the Facility.	1. Authorisation of all policies within the Facility;						
	2. Chairing of the Credentialing and Privileging Committee;						
	3. Establish a Continuing Medical Education (CME) Committee or Secretariat; and						
	4. Establish/Conduct Professional and Disciplinary Committee meetings.						
CRITERION 1.2.1.2							
The PIC or Hospital Director shall attend all meetings of the Governing Body.	1. Attendance of PIC or Hospital Director in minutes of meetings of the Governing Body.						
CRITERION 1.2.1.3							
The performance of the PIC or Hospital Director shall be regularly reviewed by the Governing Body.	1. Documented performance appraisal of PIC or Hospital Director by the Governing body.						

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STANDARD 1.2.2
APPOINTMENT, VERIFICATION OF CREDENTIALS AND PRIVILEGING
The appointment, reappointment and clinical privileges of the medical practitioners, nursing staff, and other healthcare professionals to the Healthcare Facility are appropriate to the complexity of services of the Facility. Safeguards shall be established to prevent individuals from operating beyond their competency. Appropriate mechanisms shall be in place to routinely assess the continued competency and ongoing performance of the healthcare professionals, in alignment with their job descriptions and defined scope of practice.

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CRITERION 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 for privileging and/or appointment. The membership of the Credentialing and Privileging Committee may include representatives of the Governing Body and regional representation of medical practitioners. The committee shall meet regularly to make recommendations on the privileging, appointment, and other clinical privileges of each member of the staff of the Facilities.	1. Appointment and reappointment policy according to services listed in the hospital license or approved by the Governing Body;						
	2. Credentialing and privileging policies;						
	3. Meetings are conducted as per TOR;						
	4. Agenda and minutes of meeting of the Credentialing and Privileging Committee are accessible, with actions taken, followed-up, disseminated, and acknowledged by members of the Committee and the relevant staff members; and						
	5. List of privileges conferred is available onsite.						
CRITERION 1.2.2.2							
There are written and dated specific job descriptions for all categories of staff that include:	1. An updated, specific job description is available for each staff member that includes but not limited to, the items listed in (a) to (d);						

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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; iv) qualifications required and privileges granted; v) staffing patterns; and vi) Statutory Regulations.	2. Job description includes specialisation skills;						
	3. Relevant privileges granted where applicable; and						
	4. The job description is acknowledged by the staff, signed by the Head of Service and dated.						
CRITERION 1.2.2.3 (CORE)							
The criteria and mechanism taken by the Facility in determining appointments and/or clinical privileges shall adhere to the following: a) Written policies and procedures for Appointment, Credentialing, and Privileging; b) Decisions made are objective, fair, and impartial; c) Reappointments and/or privileges shall each be granted for a specified period of time; d) When appropriate, temporary appointments	1. Written policies and procedures for Appointment, Credentialing, and Privileging; and						
	2. Credentialing and Privileging criteria include items (b) to (e)						

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and/or privileges may be granted for a limited period of time according to a policy approved by the Governing Body; and e) Appointments and/or privileges are allocated in such a way that each staff functions within a specified area of competence.							
CRITERION 1.2.2.4 (CORE)							
Criteria for determining appointments and/or clinical privileges shall be specified and uniformly applied to all applicants based on the following principles: a) The criteria are designed as such to ensure that patients shall receive safe and quality care; b) The criteria shall include evidence of current competence, relevant training and/or experience and current registration with the local professional registration bodies, e.g., MMC and other criteria may apply e.g., the needs of the Facility; c) Personal recommendations may be taken into account when recommendations for individual appointments and/or privileges are being considered; and d) The relevant department and/or major professional	1. Agenda and minutes of meetings of the Credentialing and Privileging Committee are accessible, with actions taken, followed-up, disseminated, and acknowledged by relevant members of the Committee; 2. Criteria for privileging rights to include items (b) and (c); 3. Recommendations from referee; and 4. Presence of relevant Head of Service at award of privileging rights to the individual at the Credentialing and Privileging Committee meeting.						

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
services shall be represented when recommendations for individual appointments and/or privileges are being considered.							
CRITERION 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 the applicants; c) the verification that relevant staff members are registered with the relevant national registers (e.g., Malaysian Medical Council - MMC and other including the 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 or she is capable of carrying out the duties and privileges to be accorded; and	1. The process of granting clinical privileges shall include items (a) to (g).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
g) the resources available in the Facility support the duties and privileges.							
CRITERION 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.	1. Certified privileging certificates						
CRITERION 1.2.2.7							
Clinical privileges may be granted for a limited period. If so, there shall be a provision for reappointment of the staff and for review of clinical privileges taking into account the individual's professional performance, peer recommendations, and other parameters of current competence. Examples of activities include: a) Participation in safety and performance improvement activities and measurement of performance outcomes; b) Continuing professional development (CPD)/CME or continuing nursing education (CNE); c) Maintenance of adequate medical records; d) Appropriate code of conduct; e) Health status f) Feedback from multi-source evaluations (e.g., peer,	1. The reappointment and renewal of clinical privileges shall consider items (a) to (h);						
	2. Provision of:						
	a. Variation (addition or omission);						
	b. Interim suspension and opportunity for retraining;						
	c. Fast tracking of privileges; and						
	d. Revocation of privileges.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
nursing, patient experience surveys where appropriate); g) Participation in quality improvement and safety activities; h) Demonstration of ethical practice and adherence to a just culture principle. The mechanism shall also allow for variation (addition or omission), as well as continuation and interim suspension of existing privileges, as appropriate. Fast track privileging may also be allowed in special cases.							
CRITERION 1.2.2.8							
There is an avenue for appeals when decisions on appointments and clinical privileges by the Credentialing and Privileging Committee are adverse to the applicant. This mechanism provides for review of decisions by an independent appeal committee or equivalent, 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.	1. Appeal Policy on clinical privileges is available; and						
	2. Policy on appointment of Appeal Committee (should be the medical staff by-law).						

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STANDARD 1.2.3

The PIC or Hospital Director shall ensure an effective human resource management system is in place in order for the Facility to operate efficiently.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 1.2.3.1 (CORE)							
The PIC or Hospital Director shall ensure that an adequate number of appropriately qualified staff are available to meet the needs of patient care.	1. Staff master plan;						
	2. Staff patient ratio appropriate to level of care;						
	3. Duty roster;						
	4. Job description; and						
	5. Policy and procedures on qualification verification.						
CRITERION 1.2.3.2							
The PIC or Hospital Director shall establish and maintain policies and practices for staff planning that support safe patient care. These policies shall be – a) in writing 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; and c) established to include a procedure for notifying employees of changes in the policies.	1. Human Resource policies;						
	2. Employee Handbook;						
	3. Policies are updated, endorsed and dated; and						
	4. Changes in the policies are communicated to the relevant staff members.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 1.2.3.3							
The PIC or Hospital Director shall maintain accurate, complete, and confidential staff records. These shall include but not limited to the following: 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; and i) Records on disciplinary action.	1. Staff personal records which include but not limited to items (a) to (i); and						
	2. Staff personal records are kept confidential.						
CRITERION 1.2.3.4							
The staff shall receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.	1. Performance appraisals for relevant staff members are completed upon probationary period and as an annual exercise.						
CRITERION 1.2.3.5							
There shall be evidence that staff are involved in the appraisal of their performance.	1. Evidence of relevant staff members involvement in the appraisal of their performance.						

STANDARD 1.2.4

The Governing Body through the PIC or Hospital Director shall ensure that staff follow the professional ethics of their respective professional bodies.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 1.2.4.1							
The PIC or Hospital Director 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.	1. Policies on ethical issues;						
	2. Ethics Committee or any other committees where ethical issues are discussed as an agenda; and						
	3. Agenda and minutes of meetings are accessible, with actions taken, followed-up, disseminated, and acknowledged by the relevant members of the Committee.						

STANDARD 1.2.5

The Governing Body through the PIC or Hospital Director 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 and enhance their competencies, thereby improving the function of the individual service.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 1.2.5.1 (CORE)							
There shall be a planned orientation programme for the newly appointed members of the Governing Body and Board of Visitors.	1. Orientation programme for Governing Body and Board of Visitors;						
	2. Orientation module; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	3. Attendance list.						
CRITERION 1.2.5.2							
There shall be a planned orientation programme (physical, virtual or both) for all categories of newly appointed staff including medical practitioners. This programme is appropriate to the size of the Facility and shall include the following: a) Information on the Vision, Mission and value 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 including business continuity responsibilities; d) Information about safety procedures including universal/standard precautions; e) Incident reporting procedures;	1. Policy requiring all new staff to attend a structured orientation programme; 2. There is orientation programme relevant topics but not limited to the topics covered from (a) to (g) and supported by an individual area/unit specific orientation checklist/programme; and 3. Attendance list.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
f) Provision for the acquisition of necessary additional skills; and g) Explanation of the methods that will be used to evaluate staff performance.							
CRITERION 1.2.5.3 (CORE)							
There is a planned staff development programme based on Training Needs Assessment which provides in-service and continuing education opportunities for all categories of staff to pursue work-related or professional interests and to adapt to evolving practices by leveraging cutting-edge digital technologies and Artificial Intelligence (AI). The PIC or Hospital Director, whenever possible, shall make resources available to allow implementation of such programmes (This may be done in collaboration with other organisations).	1. A facility-wide staff development plan is available, dated, and reviewed based on training needs assessment;						
	2. Staff involved in care delivery are consulted before implementing Artificial Intelligence (AI) systems, including their benefits and implications;						
	3. Agenda and minutes of the Training Committee are accessible, with actions taken, followed-up, disseminated, and acknowledged by the relevant members of the Committee;						
	4. Training calendar including in-house/external courses/ workshop/conferences;						
	5. Contents of training programmes shall include patient centric topics and business continuity plan (BCP);						
	6. Training records on continuing education activities are kept and maintained for each relevant staff member; and						
	7. Allocation of training budget.						

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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, a formal written agreement stating the terms of reference and the requirements of the teaching needs shall be available.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 1.2.6.1 (CORE)							
There shall be written agreements which shall include the following: a) Lines of communication; b) Provision of appropriately qualified staff to provide clinical supervision; c) Student activities shall be fully supervised; d) The faculty staff participating in the teaching/training and patient care of all categories of students in the facility shall be 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; and g) Indemnity.	1. Memorandum of agreement to include items (a) to (g);						
	2. Joint management committee;						
	3. Agenda and minutes of meetings are accessible, with actions taken, followed-up, disseminated and acknowledged by the relevant staff members;						
	4. Contracts where applicable (private institutions); and						
	5. Compliance with the Memorandum of Agreement/contract.						

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STANDARD 1.2.7 (NEW)

The Governing Body through the PIC or Hospital Director shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the workforce, ensuring a safe and healthy work environment. The term 'workforce' encompasses all individuals employed by the organisation, independent practitioners granted practice privileges, contracted personnel providing services on behalf of the organisation, and volunteers engaged in the service delivery.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 1.2.7.1 (CORE)							
The organisation shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being.	The promotion of staff well-being may involve the following:						
	a. A health-promoting environment, e.g., stress management, staff engagement opportunities, workload monitoring, management of work life balance, healthy, lifestyle programmes e.g. Workplace Wellness Programs, Community-Based Health Initiatives;						
	b. Staff being provided with appropriate supervision, support, and advice e.g., Mentor Mentee; and						
	c. Clear procedures for the effective management of underperformance e.g., feedback on performance review or performance appraisal report.						
CRITERION 1.2.7.2 (CORE)							
There is an established and safe, mechanism for staff to express grievances, provide suggestions	1. Staff suggestions and grievance reporting and processing mechanisms are available;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of *psychological safety.	2. The resolution of workplace issues may involve the following:						
		a. Measures and evidence of staff protection including whistleblowers against violence, bullying, and harassment e.g., awareness campaigns, anonymous reporting channel, Whistleblower policy; and					
		b. Documented policies and procedures for violence activation and staff protection.					
CRITERION 1.2.7.3							
A system shall be created to gather staff feedback about their workplace experience which shall be analysed and used to make improvements that enhance the work environment, staff satisfaction, and organisation culture.	1. Staff feedback (e.g., minutes of sessions or staff satisfactions survey):						
		a. Evidence of action or improvement taken.					
CRITERION 1.2.7.4 (NEW)							
The organisation shall track sick leave and staff turnover, using the following data to improve wellbeing, engagement, and retention. Management shall also review industry-specific challenges, particularly in sectors with major staffing shortages, to enhance retention strategies. Data analysis shall support better workforce planning.	1. Evidence that workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments. The results shall be used to create focused actions that improve staff well-being, solve problems, and help retain employees.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 1.2.7.5							
The organisation shall integrate equality, diversity, inclusion, and equity (EDIE) into all workforce practices, such as hiring, scheduling, and promotions. These principles shall be actively monitored, reviewed, and upheld through systematic measures. Key actions to promote EDIE shall include the following: a) Implement and enforce equal opportunity policies, including support for people with disabilities; b) Train staff on EDIE to foster a respectful workplace; c) Regularly monitor and review EDIE policies for effectiveness; d) Analyse workforce data (e.g., hiring, promotions) to identify and address gaps; and e) Strengthen team cohesion through support groups, inclusive activities, and open discussions.	1. Documented policies and procedures; and						
	2. Compliance with policies and procedures through data analytics and justifications for non-compliances.						

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TOPIC 1.3
POLICIES AND PROCEDURES

STANDARD 1.3.1
The Governing Body through the PIC or Hospital Director 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. The facility also needs to develop policies and procedures, and the terms of reference to support the physical, mental and spiritual wellbeing and professional development of their workforce in an environmentally sustainable healthcare and social care to keep people safe at work.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 1.3.1.1 (CORE)							
In determining the policies and procedures, the PIC or Hospital Director 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/documented in the policy manuals; c) determined only on the basis of adequate information and consultation; d) able to guide those making decisions; e) also based on adequate, reliable, and risk-informed data; f) capable of being implemented; and g) relevant with current Acts, Regulations, and By-Laws.	1. Facility-wide Operational Policies;						
	2. Medical Staff By-Laws;						
	3. Departmental/Service operational policies and procedures; and						
	4. Policies are relevant with current Acts, Regulations, and By-Laws.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 1.3.1.2							
The PIC shall ensure that the activities of the Facility are monitored and consistent with the written policies.	1. Results of audits;						
	2. Reports on supervisory visits (24 hours nursing report); and						
	3. 24 hours Facility reports (Maintenance Department's report).						
CRITERION 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.	1. Policies and procedures are updated, endorsed, and dated; and						
	2. Evidence of periodic review.						
CRITERION 1.3.1.4 (CORE)							
Policies and procedures are widely communicated throughout the Facility.	1. Circular or memos on new policies;						
	2. Training and briefing on the current policies and procedures;						
	3. Agenda and minutes of meetings are accessible, with actions taken, followed-up, disseminated and acknowledged by the members of the committee and relevant staff members;						
	4. Circulation list and acknowledgement;						
	5. Audits on staff compliance; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	6. Documented Nursing Care Plan signed and dated.						

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TOPIC 1.4
FACILITIES AND EQUIPMENT

STANDARD 1.4.1
The Governing Body through The PIC or Hospital Director is responsible for ensuring the availability of adequate facilities, equipment, and digital care infrastructure so as to enable the achievement of the objectives of the Facility, in keeping with all current applicable Acts, Regulations, and By-Laws.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 1.4.1.1							
The PIC or Hospital Director shall ensure that the facilities and equipment provided/available in the Facility are adequate and safe for the level of services provided.	1. Adequate facilities and equipment are available and in good working condition at each service area for safe care;						
	2. Appropriate type of equipment to match the complexity of services;						
	3. Testing, commissioning and calibration records (certificates or stickers);						
	4. Certification of equipment from certified bodies, e.g., Standards and Industrial Research Institute of Malaysia (SIRIM), The Energy Commission, Medical Device Authority (MDA), etc. as evidence of compliance to the relevant standards and Acts;						
	5. The equipment compliance with environmental regulations which include Environmental Quality Act 1974 [Act 127];						
	6. Planned replacement of equipment based on life cycle reports;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	7. Planned refurbishment of the Facility/New facilities;						
	8. Provision for budget allocation; and						
	9. Establishment of Procurement Committee.						
CRITERION 1.4.1.2 (CORE)							
There is an established programme for the maintenance of facilities and equipment, including outsourced services prioritising assets based on their criticality to core services, safety impact, and role in sustaining operational continuity.	1. Planned Preventive Maintenance (PPM) records, such as schedule, stickers, etc;						
	2. Planned Replacement Programme (PRP) where applicable;						
	3. Complaint records;						
	4. Asset inventory; and						
	5. Disposal of assets according to policies and procedures and regulatory requirements.						
CRITERION 1.4.1.3							
There are planned upgrading and replacement programmes for facilities and equipment.	1. Master plans for upgrading and replacement for facilities and equipment.						
CRITERION 1.4.1.4 (NEW)							
When adopting AI for care delivery, the management shall establish policies to evaluate its clinical relevance and technical feasibility. These policies shall include stakeholder engagement, risk assessments (e.g., for	1. Documented process for evaluating digital care systems;						
	2. AI systems managed per national regulations (e.g., National Artificial Intelligence Office (NAIO));						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
cybersecurity and data privacy), staff training, and continuous monitoring. Strategies shall also ensure equitable access by addressing digital literacy barriers and offering alternatives like in-person (face-to-face) support, phone services, and digital navigation assistance.	3. Technical expertise available for system use/maintenance;						
	4. Monitor & evaluate AI use to ensure safety and mitigate risks;						
	5. Measures are in place to prevent digital care from disadvantaged patients without devices or internet access.						

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TOPIC 1.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 1.5.1
The Governing Body through the PIC shall establish, implement, and monitor Risk Management and Business Continuity Management (BCM) programme. This programme shall support systematic identification, mitigation, and communication of clinical and non-clinical risks and strategies to ensure continuity of operations during internal or external disruptions. The plan shall comply with the relevant Acts, Regulations, and By-Laws and shall be aligned with the hospital's strategic direction and essential service priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 1.5.1.1 (CORE)							
The Business Continuity Management (BCM) Framework and Risk Management shall be a structured approach to safety improvement and organisational resilience which shall include, but not be limited to, the following elements: a) A centralized risk register encompassing clinical, operational, and ICT/cybersecurity, and environmental sustainability domains, which includes – i) clearly assigned risk owners; ii) idefined mitigation actions; iii) documented contingency plans; ongoing monitoring of residual risk levels post-treatment. b) Business Impact Analysis (BIA) to identify critical	1. Establishment of Business Continuity Management (BCM) Framework and Risk Management, which include the following:						
		a. Hospital-wide BCM policy approved by top management; and					
		b. Formation of BCM Committee with an appointed coordinator.					
	2. Implementation of Risk Management and BCM activities, including but not limited to the following:						
		a. Centralised Risk Register covering clinical, operational, and IT risks, with assigned owners and treatment plans;					
		b. Business Impact Analysis (BIA) identifying and prioritising critical functions during disruptions;					
		c. Contingency Plans for service continuity, including workaround strategies;					
		d. Simulation/Testing of plans with continuous improvement actions; and					

DISTRIBUTION

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
services and recovery objectives; c) Business Continuity Plans to ensure the continuity of critical business functions; and d) Supporting activities, including: i) Mortality and Morbidity Reviews; ii) Incident Reporting procedures; and iii) Grievance Mechanism.	e. Periodic Risk Assessment Reports.						
	3. Additional Risk Management Initiatives:						
	a. Full Incident Reporting Cycle;						
	i. Root Cause Analysis (RCA);						
	ii. Incident resolution; and						
	iii. Incident closure.						
	b. Clinical audit including patient safety reviews (e.g., mortality and morbidity review, etc);						
	c. Sentinel Event Investigations with appropriate corrective and preventive actions (CAPA), and oversight by the governing body; and						
	d. Grievance Mechanism, both staff and public, including grievance reporting and processing mechanisms are available.						
CRITERION 1.5.1.2							
There are clearly assigned responsibilities for safety and	1. Assigned officers.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
performance improvement activities within the services.	2. Letter of appointment/assignment.						
CRITERION 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). **Note:** 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).	1. Report on implementation of World Health Organization (WHO) Global Patient Safety Initiatives as indicated in the Appendix 1.a: World Health Organization (WHO) Global Patient Safety Initiatives.						
	2. Report on implementation of Malaysian Patient Safety Goals as indicated in the Appendix 1.b: Malaysian Patient Safety Goals 2.0 Guidelines.						
CRITERION 1.5.1.4 (CORE)							
There is tracking and trending of the following specific performance indicators (PI) 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	1. Specific performance indicators monitored, verified, and validated;						
	2. Records on tracking and trending analysis;						
	3. Remedial measures taken where appropriate; and						
	4. Availability of monitoring system for access block.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
percentage of all admitted patients; c) hospital wide patient satisfaction survey (six monthly basis); d) PI on Bed Management Unit especially Access Block; and where applicable; and e) In addition, healthcare facilities are required to monitor any other two (2) indicators with tracking and trending analysis to support its goals and objectives.							
CRITERION 1.5.1.5 (CORE)							
The results of all safety and performance improvement activities are regularly communicated to staff, relevant authorities, and the governing body. Examples of these activities include: a) enhancing patient safety (e.g., decreasing medication errors and infections); b) reducing patient readmissions; c) Improving patient flow and efficiency; and d) Implementing and optimizing electronic medical records. Furthermore, the Facility shall establish formal feedback mechanisms to ensure continuous improvement and organisational learning. These mechanisms shall include the following: a) Analysis of near misses and root cause trends;	1. The results or outcome on safety and performance improvement activities are accessible to staff;						
	2. Evidence of feedback via communication on results or outcome of safety and performance improvement activities e.g., through continuing education activities/meetings; and						
	3. Results or outcome of safety and performance improvement activities are utilised for improvement of the organisation and management of the Facility.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
b) Cross-departmental dissemination of lessons learned; and c) Promotion of a facility-wide safety culture.							
CRITERION 1.5.1.6							
Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff, and patients is preserved.	1. Documentations on performance improvement activities and performance indicators; and						
	2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						
CRITERION 1.5.1.7							
Facility performance data shall be made publicly available.	1. In the Facility's Annual Report; and						
	2. In the Facility's website or any other forms of publication.						

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SERVICE SUMMARY	
OVERALL RATING :	-
OVERALL RISK :	-

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SERVICE STANDARD 02 : ENVIRONMENTAL AND SAFETY SERVICES

PREAMBLE

The Person In Charge (PIC) shall ensure that the Facility shall be operated and maintained to provide the built environment which meets the sustainability and safety requirement through documented policies and procedures to reduce risk to patients, staff, and visitors.

These documents shall cover requirements for but not limited to hazard identification, risk assessment and mitigation, fire safety, workplace safety, disaster plan (internal and external), hazard material management, security and safety services and sustainability program.

TOPIC 2.1
ORGANISATION AND MANAGEMENT

STANDARD 2.1.1

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 or subcommittees 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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 2.1.1.1 (CORE)							
The Environmental and Safety Services shall address but not limited to the following: a) Workplace Safety (OSHA) b) Fire Safety; c) Disaster Management i) External Disaster; ii) Internal Disaster; and iii) Business Recovery Plan; d) Hazardous Material and Recyclable Waste Management; e) Security and Safety Services; f) Vector and Pest Control; g) *Sustainability and Climate Change; and	1. Operational policies of the Environmental and Safety Services address activities (a) to (h).						

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h) Mechanisms for collecting and using feedback to improve all the above activities							
CRITERION 2.1.1.2							
The Person in Charge (PIC) shall appoint an appropriately qualified person/ persons as the Head of Services, with clearly defined Terms of Reference, tenure, authority and responsibilities.	1. Person with appropriate qualification and experience appointed as Head of Services; and						
	1. Appointment/assignment letter with job description, roles and responsibilities.						
CRITERION 2.1.1.3 (CORE)							
The PIC shall designate various Committees or subcommittees to monitor, execute and manage various aspects of the Environment and Safety Services. The number and scope of Committees or subcommittees shall be based on the complexity and risk profile of the Facility (as in 2.1.1.1). Each of the Committees or subcommittees shall have an appointed Chairperson as well as an adequate number of appropriately qualified Committee members. Each Committees or subcommittees shall have clearly defined Terms of Reference (TOR), scope of activities, and tenure of membership, and a	1. The Committees and subcommittees shall have the following:						
	a. Appointment of a Chairperson and Secretary;						
	b. Terms of Reference (TOR);						
	c. Committee or subcommittee members;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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documented organisation chart that shows the functional and administrative relationships. The overall structure of the Environmental, Safety and Health (ESH) Committees and subcommittees shall be overseen by the Management Committee. The needs of any new Committees or subcommittees shall be proposed in line with any new regulatory requirements. (e.g., Fire Safety Organization, Organisasi Keselamatan Kebakaran (OKK), Energy Management Committee. Energy Efficiency and Conservative Act (EECA 2024).	d. Tenure of membership;						
	e. Frequency of meetings;						
	f. Minutes of meetings; and						
	g. Approved organisation chart with clear evidence of line of reporting, and accessible to relevant departments/services/units.						
CRITERION 2.1.1.4							
Each designated Committees or subcommittees shall ensure that annual action plans have been prepared based on the TOR 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 include measurable indicators aligned with quality	1. Approved yearly programme/action plan for each Committees or subcommittees;						
	2. Revision of programme as required;						
	3. Reports on implementation of yearly programme/action plans; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
improvement and shall be reviewed annually and as required. Each revision shall be prepared, verified and approved by authorised personnel.	4. Action plans include measurable indicators aligned with continuous quality improvement.						
CRITERION 2.1.1.5							
Regular meetings shall be held between the respective appointed Committees or subcommittees 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 relevant staff of the service and implemented.	1. Agenda and minutes of meetings of Committees or subcommittees are accessible, disseminated and acknowledged by the relevant staff of the service, and implemented;						
	2. Attendance list of members with adequate representatives of the service;						
	3. Frequency of meetings as scheduled; and						
	4. Discussions and resolutions are implemented.						
CRITERION 2.1.1.6							
There is clear evidence of coordination and cooperation amongst the various Committees and subcommittees 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	1. Minutes of meetings of the main Environmental and Safety ESH Committee and coordination meetings; and						
	2. Records on corrective and preventive actions taken.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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accessible to relevant staff when required.							
CRITERION 2.1.1.7							
The Head of Services is involved in the planning, justification and management of the budget and resource utilisation for various activities of the services.	1. Minutes of Facility-wide management meeting;						
	2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service; and						
	3. Approved budget and resources.						
CRITERION 2.1.1.8							
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:	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); and						
	f. Data on performance improvement activities, including performance indicators.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 2.1.1.9							
Where the entire Services or any part of the Services has been outsourced to any external service provider(s), the Head of 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 which shall delineate 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 the relevant Committees or subcommittees of the Facility; d) Appropriate key performance indicators; e) Arrangements for after-hours and emergency services to ensure business continuity; f) Contingency plans for dealing with problems in service delivery; g) Adequate facilities and equipment for providing the services;	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; and 3. Fixed agenda for ESH Committees or subcommittees to be discussed						

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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; and j) All incidents and accidents occurring within the outsourced services shall be reported to the ESH Committee.							

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TOPIC 2.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD 2.2.1
The Head of Services shall ensure that all designated Committees or subcommittees and relevant Units/Sections/Departments are staffed with sufficient, competent, and continually supported personnel. Staffing practices shall adhere to applicable laws and integrate ongoing capacity building, equity, and well-being principles to support objectives of the services and risk management.

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CRITERION 2.2.1.1 (CORE)							
The Chairperson and the members of the various Committees or subcommittees are appropriately qualified, trained, experienced and/or certified to meet the objectives of the services.	1. Certificates of qualification and registration of Committees or subcommittees members;						
	2. Attendance to relevant training, e.g. Safety and Health Officer (SHO) is registered with Department of Occupational Safety and Health (DOSH) and has attended National Institute of Occupational Safety and Health (NIOSH) training; and						
	3. Staff training records.						
CRITERION 2.2.1.2							
The authority, responsibilities and accountabilities of the Head of Services and the Chairpersons of various Committees or subcommittees shall be clearly delineated and documented. The Head of Services and the Chairpersons of various	1. Appointment/Assignment letter for Head of Services and chairpersons of Committees or subcommittees;						
	2. Relevant certificates and training records; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Committees or subcommittees shall be trained to address Environmental and Safety issues and risk management	3. Terms of Reference of appointment.						
CRITERION 2.2.1.3 (CORE)							
Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the needs of capacity building, equity, and staff well-being of each Committees or subcommittees and the Environmental and Safety Services. The organisation shall ensure that knowledge management and succession planning processes are in place to ensure continuity of environmental and safety services in the event of staff transfer, resignation, etc.	1. The human resource policy addresses capacity building, equity, and staff well-being;						
	2. Number of personnel meet the work requirements or as per contract (where applicable);						
	3. Qualifications of staff in accordance with statutory requirements; and						
	4. Succession planning processes and capacity building.						
CRITERION 2.2.1.4							
There shall be 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. This shall include awareness of the Facility's Business Continuity and Emergency Response plans relevant to the Environmental	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; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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and Safety Services, ensuring staff and contractors understand their roles during disruptions or emergencies. All contractors and vendors shall undergo a formal briefing on Environmental and Safety issues and disaster management by the relevant person/persons.	5. Contractors and vendors briefing records.						
CRITERION 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.	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; and						
	5. Access to digital learning platforms (if applicable).						

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STANDARD 2.2.2 (NEW)

The Environmental and Safety Services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of all staff, ensuring a safe and healthy work environment.

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CRITERION 2.2.2.1 (CORE)							
The Environmental and Safety Services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being.	1. The promotion of staff well-being may involve the following:						
	a. A health-promoting environment, e.g., stress management, staff engagement opportunities, workload monitoring, management of work life balance, healthy, lifestyle programmes e.g. Workplace Wellness Programs, Community-Based Health Initiatives;						
	b. Environmental and safety staff shall be provided with appropriate supervision, support, and advice e.g., mentor mentee program; and						
	c. There shall be clear procedures for the effective management of underperformance e.g., feedback on performance review or performance appraisal report.						
CRITERION 2.2.2.2 (CORE)							
The Environmental and Safety Services shall establish a safe mechanism for staff to express grievances, provide suggestions	1. Environmental and safety staff suggestions and grievance reporting and processing mechanisms are available; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety.	2. The resolution of workplace issues may involve the following:						
	a. Measures and evidence of staff protection including whistleblowers against violence, bullying, and harassment e.g., awareness campaigns, anonymous reporting channel, Whistleblower policy; and						
	b. Documented policies and procedures for violence activation and staff protection.						
CRITERION 2.2.2.3 (NEW)							
A system shall be created to gather environmental and safety staff feedback about their workplace experience which shall be analysed and used to make improvements that enhance the work environment, staff satisfaction, and organisation culture.	1. Environmental and safety staff feedback (e.g., minutes of sessions or nursing staff satisfactions survey):						
	a. Evidence of action or improvement taken.						
CRITERION 2.2.2.4 (NEW)							
The Environmental and Safety Services shall track sick leave and staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning.	1. Evidence that workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments. The results shall be used to create focused actions that improve well-being, solve problems, and help retain their employees.						

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TOPIC 2.3
POLICIES AND PROCEDURES

STANDARD 2.3.1
The Head of Environmental and Safety Services shall ensure the implementation of policies, procedures and guidelines that are approved by the relevant Committees or subcommittees and made accessible to all staff. Policies and procedures shall incorporate current evidence-based practices and reflect emerging approaches in person-centred safety, sustainability, and in environmental and safety management.

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CRITERION 2.3.1.1 (CORE)							
There shall be current documented policies, procedures and guidelines that govern the implementation of Environmental and Safety Services. These documents shall integrate person-centred safety approaches, sustainability practices, and relevant aspects of Environmental and Safety management systems, where applicable. There is a mechanism and evidence of a periodic review to accommodate new regulatory requirements and current best practices.	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 at least every 3 years; and						
	7. Policies incorporate “person-centred care” where applicable.						
CRITERION 2.3.1.2 (CORE)							
Cross departmental policies and procedures shall be developed in collaboration with the relevant services where applicable. The	1. Agenda and minutes of Committee or subcommittee meetings on the development and revision of policies and procedures;						

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review process shall consider updates in relevant standards and best practices, innovations in technology, sustainability practices, and evolving approaches to person-centred care.	2. Evidence of cross reference with other departments;						
	3. Documented cross departmental policies; and						
	4. Evidence that the review process considers updates in standards, technologies, and person-centred care practices.						
CRITERION 2.3.1.3							
Current policies and procedures are communicated to all staff	1. Training and briefing on the current policies and procedures;						
	2. Minutes of meetings; and						
	3. Circulation list and acknowledgement.						
CRITERION 2.3.1.4 (CORE)							
There is evidence of compliance with policies and procedures.	1. Compliance with policies and procedures through:						
	a. Staff interviews on practices;						
	b. Verify with observation on practices in line with established policies and procedures; and						
	c. Results of audit on practices.						
CRITERION 2.3.1.5							
Copies of relevant policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-	1. Copies of relevant policies and procedures, protocols, guidelines, Acts, Regulations, By-Laws and statutory requirements are						

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Laws and statutory requirements are accessible to staff.	accessible on-site for staff reference; and						
	2. Legal Register.						
CRITERION 2.3.1.6 (CORE)							
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.	1. Hard/Soft copies of relevant documents are accessible on-site and readily available for staff reference.						

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TOPIC 2.4
FACILITIES AND EQUIPMENT

STANDARD 2.4.1
The Head of Services shall ensure adequate facilities and equipment that are safe and appropriate, are available, accessible and maintained for the environment and safety staff to function effectively and to meet the goals and objectives of the Environmental and Safety Services.

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CRITERION 2.4.1.1							
There shall be adequate and appropriate facilities and equipment with proper utilisation of workplace to enable staff to carry out their professional and administrative functions.	1. Adequate facilities and proper utilisation of workplace within the Facility for staff and outsourced service providers to carry out activities that affected by the Environmental and Safety Services which shall include but not limited to the following:						
	a. Adequate rooms/cabinets/work desks/workshop areas;						
	b. Adequate storage space;						
	c. No congestion; and						
	d. Biannual occupancy evaluation risk assessment reports which shall include (a), (b) and (c).						
CRITERION 2.4.1.2							
There shall be documented evidence that equipment complies with relevant national/international standards and current statutory requirements.	1. Testing, commissioning and calibration records (certificates or stickers);						
	2. Certificates of calibration, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc; and						
	3. Certification of equipment - Certificate of fitness (Department of						

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	Occupational Safety and Health certification, Fire Authority).						
CRITERION 2.4.1.3 (CORE)							
Where specialised equipment (equipment that is high risk, requiring competency training and/or, compliance to regulatory requirements) is used, there shall be evidence that only staff who are trained and authorised by the Facility operate such equipment.	1. List of personnel authorised by the PIC to operate specialised equipment;						
	2. Training records;						
	3. Staff profile of authorised personnel;						
	4. Competency assessment records; and						
	5. Certificate/Registration of competent person as required or letter of authorisation.						
CRITERION 2.4.1.4							
Arrangements shall be made to provide person-centred comfort. These include clean and hygienic facilities, appropriate room temperature, and relative humidity and permissible noise levels.	1. Patient satisfaction survey reports; and						
	2. Staff satisfaction survey reports.						

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TOPIC 2.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 2.5.1
The Head of Services shall ensure performance improvement with staff involvement in continuous safety and performance improvement activities of the Environmental and Safety Services and Risk Management activities. This can be achieved through monitoring and tracking of Hazard Identification, Risk Assessment and Risk Control (HIRARC) and Business Continuity Management (BCM) activities. The Head of Services shall ensure compliance to environmental and safety outcomes.

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CRITERION 2.5.1.1 (CORE)							
There are planned systematic risk-based safety and performance improvement activities to monitor and evaluate the performance of the Environmental and Safety Services. The process shall include the following: 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 g) Innovation is advocated; and h) Incorporation of lessons learned from incidents, near misses, and internal or external audits.	1. Planned safety and performance improvement activities include (a) to (h);						
	2. Reports on safety and performance improvement activities and outcomes;						
	3. Agenda and minutes of safety and performance improvement meetings; and						
	4. Records on innovation, if available.						
CRITERION 2.5.1.2							
The Head of Services shall assign the responsibilities for planning, monitoring and managing safety and performance improvement activities to	1. Agenda and minutes of meetings, accessible and well disseminated and acknowledged by Committee members and the relevant staff;						

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appropriate individuals/personnel within the respective Committees/subcommittees//activities. The assignment of responsibilities shall include the identification of risk owners for key environmental and safety risks, alignment of responsibilities with the Business Continuity Management (BCM) frameworks.	2. Letter of assignment of responsibilities; and						
	3. Terms of Reference (TOR)/Job description.						
CRITERION 2.5.1.3 (CORE)							
The Head of Services shall ensure that the staff are trained and complete incident reports involving patients, staff, visitors and outsourced service providers which shall be promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the PIC of the Facility. Incidents reported shall have Root Cause Analysis (RCA) done and action shall be taken within the agreed time frame to prevent recurrence.	1. System for incident reporting is in place, which shall include the following:						
	a. Training of staff;						
	b. Procedure on incident/accident reporting;						
	c. Methodology of incident reporting; and						
	d. Register/Records of incidents.						
	2. Completed incident reports;						
	3. Full RCA Cycle;						
	4. Corrective and preventive action plans;						
	5. Remedial measure, Review of remedial measure for further improvement;						
	6. Reports to Relevant Authorities as required;						

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	7. Minutes of meetings of ESH Committee and subcommittees;						
	8. Acknowledgement by Head of Services and PIC/Hospital Director; and						
	9. Feedback given to staff regarding incident reporting.						
CRITERION 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. b) (Proposed Initial Target: 50%, 3 monthly report); c) Percentage of internal and external planned drills are carried out and documented including recommendation and followed through. d) (Target: 100%); and e) Percentage of workplace hazards identified and risk managed (Target: 100%).	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); and						
	5. Remedial measures taken, where appropriate.						
CRITERION 2.5.1.5							
Feedback on results of safety and performance improvement activities are regularly communicated to the staff and relevant authority.	1. Results on safety and performance improvement activities are accessible to staff;						

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	2. Evidence of feedback via communication on results of performance improvement activities through continuing education activities/meetings; and						
	3. Agenda and minutes of committee meetings, accessible, and disseminated and acknowledged by the relevant staff.						
CRITERION 2.5.1.6							
Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients shall be preserved.	1. Documentations on safety and performance improvement activities and performance indicators; and						
	2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						
CRITERION 2.5.1.7 (CORE)							
There shall be safety and performance improvement activities that address person-centred needs including the outsourced service providers	1. Staff health screening;						
	2. Identification of health risk factors;						
	3. Infectious diseases prevention programme/activities;						
	4. Anti-smoking programme;						
	5. Healthy lifestyle activities:						
	a. Stress management; and						
	b. Diet Programme.						

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	6. Staff training on:						
	a. Sharps and needle stick injury management;						
	b. Occupational Safety and Health (OSH);						
	c. Ergonomics; and						
	d. Biohazard waste disposal.						
	7. Medical check-up record;						
	8. Post exposure management;						
	9. Universal/standard precautions;						
	10. Protection against bullying and harassment;						
	11. Effective management of underperformance; and						
	12. Policy statement on anonymity on patients and providers involved in performance improvement activities.						

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TOPIC 2.6
SPECIAL REQUIREMENTS

STANDARD 2.6.1
OCCUPATIONAL SAFETY AND HEALTH PROGRAMMES
The Management of the Facility shall ensure that the workplace complies with the occupational safety and health standards and requirements as stipulated by Occupational Safety and Health Acts (OSHA).

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CRITERION 2.6.1.1 (CORE)							
There is a multidisciplinary Occupational Safety and Health (OSH) Committee or subcommittee 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 Occupational Safety and Health Act (OSHA) 1994.	1. OSH Committee or subcommittee is established;						
	2. Organisation chart of OSH Committee or subcommittee;						
	3. Terms of Reference of the OSH Committee or subcommittee;						
	4. Schedule of meetings for the year; and						
	5. Minutes of meetings.						
CRITERION 2.6.1.2 (CORE)							
Occupational Safety and Health (OSH) Committee or subcommittee shall be headed by a management staff trained aware in OSH standards and risk management and supported by a Safety and Health Officer (SHO) registered with the Department of Occupational Safety and Health (DOSH). The composition of the committee or subcommittee shall follow Occupational Safety and Health Act (OSHA) 1994	1. Composition of the Committee is in accordance to the OSH Act 1994 shall be as the following:						
		a. The Chairman of the committee or subcommittee shall be a management staff who is trained in OSH standards and risk management;					
		b. The secretary of the committee or subcommittee shall be the					

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requirements. The letter of appointments shall clearly define the authority, responsibilities and accountabilities for the committee members.	Safety and Health Officer SHO; and						
	c. Members are representatives of employees and employers from multidiscipline.						
	2. Letter of appointment; and						
	3. Job Scope as per Term of Reference (TOR).						
CRITERION 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.	1. ESH Committee's organisation chart showing coordination with other specific committees; and						
	2. Committee's Terms of Reference.						
CRITERION 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	1. Environment and Safety audit schedule and reports;						
	2. Risk Register and risk assessment report;						
	3. Health Promotion programme including:						
	a. Stress management; and						
	b. Diet programme.						
	4. Staff health surveillance record and statistics;						
	5. Minutes of meetings, reports and records on environmental,						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
and systems that pose risks; indoor air quality concerns; external road and drainage, ramp, floor safety; 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 - i) identification of high risk areas; ii) maintaining Risk Registers; iii) carrying out Failure Mode and Effect Analysis (FMEA); and iv) taking appropriate corrective actions to rectify the identified risks; e) investigation on reported incidents and accidents using Root Cause Analysis (RCA);	occupational safety and health activities;						
	6. Completed Incident reports;						
	7. Completed full cycle of RCA;						
	8. Business Continuity Report on follow-up actions for further improvements;						
	9. Corrective and preventive measures;						
	10. Reports to relevant authorities, e.g., sharps injury to Ministry of Health, Lost Time Accident to Department of Occupational Safety and Health;						
	11. Recovery plan for Business Continuity;						
	12. Sustainability Program;						
	13. Protection against bullying and harassment; and						
	14. Effective management of underperformance.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and i) Promote sustainability programmes that include efficiency of use of energy, water, climate, and waste. **Note:** A risk register is a log that records all the risks an organization has identified, their grading in terms of likelihood of occurring and seriousness of impact on the organisation, initial mitigating plan for managing each major risk and subsequent outcomes.							
CRITERION 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.	1. Valid registration of Safety and Health Officer with Department of Occupational Safety and Health (DOSH);						
	2. Appointment of Safety and Health Officer; and						
	3. Job description.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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CRITERION 2.6.1.6							
There is evidence that all staff are familiar with workplace environmental, safety and health programmes.	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; and						
	6. Staff comply with environmental, safety requirements.						
CRITERION 2.6.1.7							
There are written environmental and safety procedures specific to potentially hazardous areas and for hazardous substances (e.g., central sterilising supply services, food services areas, laundries, laboratories, operating suites, radiation emission areas, special units, engineering rooms and workshops).	1. Departmental specific environmental and safety policies and procedures include the following:						
	a. Central Sterilising Supply Services (CSSS);						
	b. Food Services;						
	c. Laundry;						
	d. Laboratory;						
	e. Operating Suite;						
	f. Radiation Emisssion Areas;						
	g. Engineering rooms/workshop, and						
	h. Laser safety program.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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; and						
	3. Procedure checklist.						
CRITERION 2.6.1.9							
Personal protective clothing and equipment shall be provided where required, and their usage shall be monitored. Staff shall be provided with vaccination and/or medication as necessary to perform their work safely.	1. Adequate supply of Personal Protective Equipment (PPE) and monitor stock balance;						
	2. Staff wear proper PPE; and						
	3. Staff's vaccination record.						
CRITERION 2.6.1.10							
The following are standard environmental and safety practices in handling medical gases, that shall be complied with: as follows: a) *All medical gases users shall be trained and privileged; b) 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	1. Training records (a) to (d);						
	2. Privileging rights; and						
	3. Compliance with items (a) to (c) by the Facility.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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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; and iv) storage areas are appropriately labelled/sign posted including "No Smoking" sign in accordance with statutory requirements. c) There shall be provisions of emergency suction apparatus and medical gas supplies in key areas such as operating suites, special care units, emergency services, etc.; and d) There shall ~~be~~ be adequate lighting to service areas and there is shall be provision of alternative light (emergency portable lighting) appropriate to the needs of the Facility in the event of a failure of the local supply.							
CRITERION 2.6.1.11							
The Facility shall ensure that noise, excessive smoke, foul odour or dust are minimised with evidence of surveillance report.	1. Noise mapping; 2. Indoor air quality report; and 3. Evidence of follow-up and follow through from recommendations made in the report.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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CRITERION 2.6.1.12							
The PIC shall ensure that the healthcare facility integrate Ssustainability Programme (SP) into its operations, promoting environmental sustainability, social responsibility, and ethical governance in all aspects of environmental and safety services.	1. SP Annual Reports including:						
	a. 3R;						
	b. Green Building;						
	c. Indoor Air Quality (IAQ); and						
	d. Energy Management.						
	2. Disposal records.						

STANDARD 2.6.2
FIRE SAFETY
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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	1. Building drawing approved by Fire Authority; and						
	2. Continuous Monitoring Information System (CMIS) is functional and linked to the fire station where applicable.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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CRITERION 2.6.2.2							
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.	1. Approved as built drawings by relevant professionals.						
CRITERION 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	1. Annual fire inspection report by Fire Authority;						
	2. Current Fire Safety Certificate is available for buildings; and						
	3. Facility's report on rectification of recommendations by Fire Authority where required.						
CRITERION 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.	1. Fire extinguishers have valid inspection certificates;						
	2. Testing of fire extinguishers;						
	3. Maintenance records; and						
	4. Functional fire alarm system.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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CRITERION 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.	1. Signages indicating fire fighting equipment are clearly visible.						
CRITERION 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.	1. No penetrations at fire walls and zone compartments.						
CRITERION 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.	1. Fire exit routes are unobstructed.						
CRITERION 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.	1. Fire doors kept closed at all times.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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CRITERION 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.	1. Lighted KELUAR/EXIT signs are:						
	a. clearly visible from any internal corridors;						
	b. functional; and						
	c. adequate.						
CRITERION 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.	1. Current evacuation plans are available; and						
	2. Clear signage to assembly areas.						
CRITERION 2.6.2.11							
There are adequate "No Smoking" signs posted at all entrances to the Facility.	1. No Smoking" signs are:						
	a. Visible;						
	b. Adequate; and						
	c. Placed at all entrance to the Facility.						
CRITERION 2.6.2.12 (CORE)							
There is at least one designated Fire Safety Officer assigned by the Person In Charge for every shift.	1. Assignment letter;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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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.	2. Fire Response Training records; and						
	3. Minutes of fire safety meetings.						
CRITERION 2.6.2.13 (CORE)							
The Emergency Response Team (ERT) and key Incident Management Team (IMT) shall be adequately equipped to respond during emergency.	1. ERT and IMT are established;						
	2. Emergency procedures and disaster control room facilities are available;						
	3. Training records; and						
	4. Minutes of fire safety meetings.						
CRITERION 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;	1. Approved fire evacuation and recovery plan and procedures that include items (a) to (k);						
	2. Staff awareness on fire evacuation plan and procedures including new green services such as Electric Vehicle Charging station, Solar PV and Battery Energy Storage Systems (BESS);						
	3. Staff assignment and response card;						
	4. Training records for all staff including on-site outsourced staff covering specific risks, response protocols and firefighting measures for new technologies; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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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; and k) other provisions as the local situation dictates.	5. Evacuation drills involve equipment or method used for non-ambulatory or assisted persons.						
CRITERION 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.	1. Records and reports on annual fire drills; and						
	2. Staff attendance list.						
CRITERION 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	1. Staff awareness on fire and evacuation plan; and						
	2. Records on training of key assigned personnel and staff on specific aspects of fire safety.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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fighting equipment, fire evacuation procedures and evacuation of non-ambulant patients.							

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STANDARD 2.6.3
DISASTER MANAGEMENTS

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:

a) 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.

b) 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.

c) Business Continuity Plan (BCP) - Is a strategic framework that ensures an organization can continue operating during and after a disruptive event, such as a natural disaster, cyberattack, or supply chain failure. It focuses on maintaining essential functions and recovering critical operations with minimal downtime.

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CRITERION 2.6.3.1							
EXTERNAL DISASTER PLANS The Facility has an appropriate external disaster plan, based on its capabilities and as follows: a) 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 command, clarify	1. External Disaster Plan that addresses items (a) to (c);						

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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;	2. List of relevant agencies and their contact numbers;						
	3. Adequate resources as per disaster plan;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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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;	4. Records on relevant staff training on the disaster plan;						
	5. Staff response card;						

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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;	6. Drills and training records;						
	7. Reports on the Disaster Drill and actual disaster (if applicable);						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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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; and 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; and iv) review and revise the plan as necessary.	8. Evaluation on Disaster Drill and actual disaster (if applicable); and						
	9. Revision of External Disaster Plan as necessary.						
CRITERION 2.6.3.2 (CORE)							
INTERNAL DISASTER PLANS The Facility shall have documented internal disaster plans for all	1. Internal Disaster Plan that include potential internal disasters (a) to (i);						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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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; and k) 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.	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); and						
	8. Revision of Internal Disaster Plan as necessary.						
CRITERION 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;	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;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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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; and 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	7. Control copy of Internal Disaster Plan is easily accessible to staff; and						
	8. Staff awareness on Internal Disaster Plan.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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enable performance of assigned tasks; ii) evaluate the effectiveness of the plan; iii) evaluate and document the exercise; and iv) review and revise the plan as necessary. c) The Internal Disaster Plan shall be readily available for staff reference; and d) Staff are familiar with the internal disaster plans and shows understanding of the plans that are displayed throughout the Facility.							
CRITERION 2.6.3.4							
BCP shall be formulated for all major disasters that affected normal hospital service operations 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 have been taken care of; c) To conduct post mortem to identify better precautionary steps and improving the disaster management process; and d) Continuously improve the preventive and mitigation measures in recovery plan for the future.	1. BCP that addresses item (a) to (d); and 2. Reports of BC after disaster.						

STANDARD 2.6.4
HAZARDOUS MATERIAL MANAGEMENT
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.

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CRITERION 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.	1. Valid report on Chemical Health Risk Assessment by competent person.						
CRITERION 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.	1. Records on staff training.						
CRITERION 2.6.4.3							
Staff shall wear appropriate personal protective equipment when handling hazardous materials.	1. Staff and contractors wear appropriate personal protective equipment; and						
	2. Implementation of 5R strategy namely “Rethink, Reduce, Reuse, Recycle and Replace” where possible.						
CRITERION 2.6.4.4							
Staff shall be trained to handle spillage and appropriate spill kits are located appropriately.	1. Policy and procedures on handling spillage;						
	2. Staff able to demonstrate the procedures on handling spillage; and						

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	3. Adequate spillage kits are available.						
CRITERION 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.	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; and						
	d. Radioactive waste.						
	3. Eyewash and shower for chemical handling; and						
	4. Handwashing facilities.						
CRITERION 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; and c) the clinical waste store shall be refrigerated if the wastes are stored for more than 24 hours.	1. Proper storage including containment of chemicals in appropriate and right size cabinets and/or rooms; and						
	2. Clinical waste store is refrigerated at temperature 4°C - 6°C if the wastes are stored for more than 24 hours.						
CRITERION 2.6.4.7							

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
There has to be a dedicated route for waste transportation. No mixing between clean and dirty waste materials.	1. Policy and procedures address the route/timing of waste transportation; and						
	2. Dedicated route for transportation of waste.						
CRITERION 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.	1. Approval letter from Department of Environment for transporting scheduled waste outside the premises; and						
	2. Consignment note available.						

STANDARD 2.6.5
DOMESTIC AND RECYCLED WASTE
The disposal of domestic and recycled wastes is carried out in accordance with legislation requirements of the Department of Environment and local authority.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 2.6.5.1							
Domestic, recycled and food wastes shall be removed daily and the main storage area shall be kept clean.	1. Domestic, recycled and food wastes areas are kept clean; and						
	2. Schedule on collection of domestic, recycled and food wastes from local authority/local contractors.						
CRITERION 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.	1. Policy and procedures for recycling waste;						
	2. Compliance with policy and procedures; and						
	3. Implementation of 5R strategy namely “Rethink, Reduce, Reuse, Recycle and Replace”.						

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STANDARD 2.6.6
SECURITY SERVICES
Security Services shall include physical security measures, crime prevention and response and emergency response coordination to ensure are taken to ensure the protection of patients and staff from assault and loss of property; and the Facility from damage and loss.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 2.6.6.1 (CORE)							
The head of security services must be knowledgeable and trained to conduct security risk assessments which include: a) Physical security measures: i) Access control; ii) Surveillance system; and iii) Security personnel. b) Crime prevention and response i) Infant abduction prevention; ii) Violent prevention; and iii) Theft control. c) Emergency response i) Collaboration with law enforcement agencies; and ii) Internal Disaster.	1. Training records; and						
	2. Security Risk Assessment Report.						
CRITERION 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	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;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
personal belongings, payroll, drugs, and other assets of the Facility.	4. Reports on performance of the security system; and						
	5. Security incident reports.						
CRITERION 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.	1. Security personnel is present at important areas at all times;						
	2. Records on clearance from Ministry of Internal Affairs for all security personnel; and						
	3. Training records on security personnel.						

STANDARD 2.6.7
VECTOR AND PEST CONTROL SERVICES
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 infections and diseases.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Vector and pest control schedule as per agreement and records on activities.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. No vectors and pests seen in the facility buildings and grounds.						
CRITERION 2.6.7.3							
There is planned regular vector control programme.	1. Dengue control activities; and						
	2. Records on inspection of mosquito breeding areas.						

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STANDARD 2.6.8 (NEW)
SUSTAINABLE CARE
Healthcare buildings are organised to be environmentally sustainable and to reduce harm to the environment in their daily operation and build resilience to challenges such as climate change, extreme weathers, and health emergencies.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 2.6.8.1							
There is documented evidence that the health organization shall adopt a sustainability approach with organizational strategy and operational practice to promote environmental stewardship, social responsibility, economic viability, regulatory compliance, and disclosure.	1. Established document reflecting commitment to environmental stewardship, social responsibility, and economic sustainability, aligned with Sustainable Development Goals (SDGs) and applicable Environmental, Social, and Governance (ESG) reporting framework.						
CRITERION 2.6.8.2 (CORE)							
The organization must share information with their staff and patients about their sustainable care and goals.	1. Staff briefing and training session;						
	2. Brochures or handouts explaining the organization's environmental initiatives; and						
	3. Posters and infographics.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 2.6.8.3							
Organization shall develop policy and procedures to address climate change risk and opportunities including carbon management, greenhouse gas emission reduction (GHG) and resilience of the bill requirement	1. Policy and procedures to address climate change risk and opportunities including carbon management, greenhouse gas emission reduction (GHG) and resilience of the bill requirement.						
CRITERION 2.6.8.4 (CORE)							
Sustainable sourcing and supply change management shall ensure that the procurement and sourcing policy shall prioritise criteria such as green material, circular economy principle (5R; Refuse, Reduce, Reuse, Repurpose, Recycle) and supplier social responsibility.	1. Evidence of compliance to 5R; and						
	2. Performance supplier evaluation.						
CRITERION 2.6.8.5							
Waste and energy management shall develop a plan and control for waste segregation, recycling and energy consumption monitoring. Water use reduction program and resource optimization shall be plan executed and periodically reviewed for effectiveness.	1. Waste monitoring report;						
	2. Energy management program; and						
	3. Monitoring water consumption in area such as Lab, CSSD, dialysis.						
CRITERION 2.6.8.6							
There is an energy management programme in place compliance to Energy Efficiency and Conservation Act (EECA) 2024 and includes the following:	1. Appointment of Registered Energy Manager in accordance to National Energy Commission guidelines;						
	2. Energy management programme is available;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
a) A registered energy manager shall be appointed by the facility if the Facilities consuming 21,600 GigaJoule period of twelve consecutive months with advanced qualifications required if consumptions exceeds 50,000 GJ/year under the Energy Efficiency and Conservation Regulations 2024; b) The facility may appoint an external Registered Energy Manager (REM) for up to three years, after which an internal REM must be appointed in compliance with national energy regulations; c) The Sustainable Energy Management Committee shall be established to carry out the following activities with the involvement of the Energy Manager: i) establish policies and procedures, support the energy management committee to implement, maintain and continually improve the effective usage of electrical energy in accordance with the regulatory requirements; ii) identify, perform, set up energy targets, plan and manage the energy consumption through the Sustainable Energy	3. Energy audit reports;						
	4. Copies of reports to Energy Commission; and						
	5. Minutes of Sustainable Energy Management Committee.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Management Programme (SEMP); iii) conduct technical audits that include financial evaluation for energy conservation measures. d) The energy management programme complies with regulatory requirements and should not compromise the safety and comfort of patients and staff.							
CRITERION 2.6.8.7							
The facility shall conduct assessment and reduction program of carbon footprint by evaluating the greenhouse gas (GHG) emission through their care services initiative taken to reduce it over time.	1. Monitoring report on GHG emissions with Tracking and trending.						
CRITERION 2.6.8.8 (CORE)							
The healthcare organization is advised to assess the risk and to develop the response plan that prioritises safety and continuity of care.	1. Risk assessment report; and						
	2. Emergency plan including staff awareness and authority collaboration.						

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SERVICE SUMMARY	
OVERALL RATING :	-
OVERALL RISK :	-

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SERVICE STANDARD 03: FACILITY AND BIOMEDICAL EQUIPMENT MANAGEMENT AND SAFETY

PREAMBLE

The Healthcare Facility shall be designed, constructed, equipped, operated and maintained to create the built in environment meeting clinical standards for the service providers to perform Healthcare Services without compromising patient, visitor and staff safety.

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.

These services may be provided from within the Facility by either its own staff or contract staff, or contracted to qualified external contractors.

TOPIC 3.1
ORGANISATION AND MANAGEMENT

STANDARD 3.1.1
The Facility and Biomedical Equipment Management and Safety Services shall be organized 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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 3.1.1.1 (CORE)							
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	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 is in line with the vision and mission of the healthcare facility;						
	3. Evidence of planned reviews of the above statements;						
	4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc); and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
accordingly and communicated to all staff.	5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.						
CRITERION 3.1.1.2							
There is an organization 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) Organization; ii) Functions; iii) Reporting relationships; iv) Staffing patterns.	1. Clearly delineated current organization chart with line of functions and reporting relationship;						
	2. Organization chart of the service is endorsed, dated and accessible; and						
	3. The organization chart is revised when there is a major change in any of the items (d)(i) to (iv).						
CRITERION 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	1. The Contract Agreement between the Facility and the external service provider(s) address items (a) to (j); and						
	2. Evaluation of service provider performance.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; 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; and j) Comply with the appropriate MSQH Standards of							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Accreditation for Facility and Biomedical Equipment Management and Safety Services.							
CRITERION 3.1.1.4							
Regular staff meetings (minimum quarterly) 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. Unresolved matters to be brought up and discussed at the hospital management meeting. 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); and						
	5. Minutes of unresolved matters discussed at the hospital management meeting.						
CRITERION 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 utilization of the services.	1. Minutes of Facility-wide management meeting;						
	2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service; and						
	3. Approved budget and resources.						
CRITERION 3.1.1.6							
The Head of Facility and Biomedical Equipment	1. Records on staff interview (if applicable);						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Management and Safety Services is involved in the appointment and/or assignment of staff as well as endorsement of vendor.	2. Appointment/assignment letter of Head of Service;						
	3. Job description of Head of Service;						
	4. Records on staff deployment;						
	5. Duty roster; and						
	6. Records on evaluation of vendor's performance.						
CRITERION 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.	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;						
	d. Accident/incident reports;						
	e. Staffing number and staff profile; and						
	f. Staff training records.						

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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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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; and						
	2. The head of service or any management staff shall possess at least 3 years experiences in healthcare facility management.						
CRITERION 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	1. Appointment/assignment letter for Head of Service; and						
	2. Description of duties and responsibilities.						
CRITERION 3.2.1.3 (CORE)							
Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the need of the services.	1. Number of staff and qualification should commensurate with facilities workload requirements;						
	2. Staff to have valid registration with professionals and relevant authorities bodies;						
	3. Staffing pattern;						
	4. Duty roster; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	5. Census and statistics.						
CRITERION 3.2.1.4 (CORE)							
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; and 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; and vi) Statutory Regulations.	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 specialization skills;						
	3. Certification by relevant bodies; and						
	4. The job description is acknowledged by the staff and signed by the Head of Service and dated.						
CRITERION 3.2.1.5							
Personnel records on training, staff development, leave and others are maintained for every staff. **Note:** Staff personal records may be kept in Human Resource Department as per hospital policy.	1. Staff personal records include:						
	a. Staff biodata;						
	b. Qualification and experience;						
	c. Evidence of current registration;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	d. Training record;						
	e. Competency record and certification from relevant bodies; and						
	f. Confidentiality agreement.						
CRITERION 3.2.1.6							
There is a structured orientation programme where new staff are briefed on their services, operational policies and procedures and relevant aspects of the Facility to prepare them for their roles and responsibilities.	1. Policy and Procedures requiring all new staff to attend a structured orientation programme;						
	2. Records on structured orientation programme;						
	3. Orientation module; and						
	4. List of attendance.						
CRITERION 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.	1. Training needs assessment is carried out and includes various risks and gaps to match the competencies and skills identified;						
	2. A staff development plan based on training needs assessment is available;						
	3. Training schedule/calendar is in place; and						
	4. Training module.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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; and						
	5. Specific training programme on clinical risks attended.						
CRITERION 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.	1. Performance appraisal for staff is completed upon probationary period and as an annual exercise;						

STANDARD 3.2.2 (NEW)
The facility and biomedical services shall be responsible for promoting and supporting the physical, mental spiritual wellbeing and performance of the staff, ensuring a safe and healthy work environment.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 3.2.2.1 (CORE) (NEW)						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
The facility and biomedical services shall have provisions for the promotion of staff physical, mental, spiritual well-being and performance.	1. The promotion of staff well-being may involve the following:						
	a. A health-promoting environment, e.g., stress management, staff engagement opportunities, workload monitoring, management of work life balance, healthy, lifestyle programmes e.g. Workplace Wellness Programs, Community-Based Health Initiatives;						
	b. Facility and biomedical staff shall be provided with appropriate supervision, support, and advice e.g., mentor mentee program; and						
	c. There shall be clear procedures for the effective management of underperformance e.g., feedback on performance review or performance appraisal report.						
CRITERION 3.2.2.2 (CORE) (NEW)							
The facility and biomedical services shall establish a safe mechanism for their staff to express grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety.	1. Facility and biomedical staff suggestions and grievance reporting and processing mechanisms are available;						
	2. The resolution of workplace issues may involve the following:						
	a. Measures and evidence of facility and biomedical staff protection including whistleblowers against						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	violence, bullying, and harassment e.g., awareness campaigns, anonymous reporting channel, Whistleblower policy; and						
	b. Documented policies and procedures for violence activation and facility and biomedical staff protection.						
CRITERION 3.2.2.3 (NEW)							
A system shall be created to gather facility and biomedical staff feedback about their workplace experience such as burnout which shall be analyzed and used to make improvements that enhance the work environment, staff satisfaction, and organization culture.	1. Facility and biomedical staff feedback (e.g., minutes of sessions or facility and biomedical staff satisfactions survey):						
	a. Evidence of action or improvement taken.						
CRITERION 3.2.2.4 (NEW)							
The facility and biomedical services shall track sick leave and staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning	1. Evidence that workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments. The results shall be used to create focused actions that improve facility and biomedical staff well-being, solve problems, and help retain their employees.						

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TOPIC 3.3
POLICIES AND PROCEDURES

STANDARD 3.3.1
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 and Business Continuity Plan (BCP) of the Facility and Biomedical Equipment Management and Safety Services, relevant regulations and statutory requirements.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 3.3.1.1 (CORE)							
There are written plan, policies, procedures and work instructions for the Facility and Biomedical Equipment Management and Safety Services which are consistent with the overall documented policies of the Facility, regulatory requirements, and current standard practices and department risk management. Department risk management process is aligned with Facility operation & policies. 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.	1. Documented information (policies, procedures, records) for the service including master list;						
	2. Policies and procedures are consistent with regulatory requirements and current standard practices;						
	3. Policies, procedures and work instructions are updated, endorsed and dated;						
	4. Periodic review;						
	5. Risk Management Policy; and						
	6. Business Continuity Plan (BCP).						
CRITERION 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.	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; and						
	3. Documented cross departmental policies.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Cross departmental collaboration is practiced in developing relevant policies and procedures where applicable.							
CRITERION 3.3.1.3							
Current policies and procedures are communicated to all staff	1. Training and briefing on the current policies and procedures/Minutes of meetings; and						
	2. Circulation list and acknowledgement.						
CRITERION 3.3.1.4 (CORE)							
There is evidence of compliance with policies and procedures	1. Compliance with policies and procedures through:						
	a. Interview of staff on practices;						
	b. Verify with observation onpractices;						
	c. Results of audit on practices;						
	d. Practices in line with established policies and procedures; and						
	e. Compliance reports.						
CRITERION 3.3.1.5							
Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are available and accessible to staff	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are available and accessible on-site for staff reference.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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; d) Communication system (pabx/telephone/nurse call system/pa system); and e) Internet connectivity.	2. Policies and procedures for emergency response plan (ERP) that address items (a) to (d) are in place;						
	3. Availability of Emergency Response Team (ERT);						
	4. Contact numbers of staff in-charge/relevant authorities/ vendors/suppliers are made available;						
	5. Flow chart online of communication; and						
	6. Business Continuity Plan (BCP).						
CRITERION 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.	1. Evidence risk identification, risk assessment and risk control;						
	2. Documented permit for any Facilities/Mechanical and electrical works from the relevant authority is available if any works authorized; and						
	3. All relevant tests satisfactorily done for new works.						

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TOPIC 3.4
FACILITIES AND EQUIPMENT

STANDARD 3.4.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 3.4.1.1 (CORE)							
The PIC and the Head of Facility and Biomedical Equipment Management and Safety Services shall ensure there are adequate and appropriate facilities and equipment with proper utilization of space to enable staff to carry out their professional and administrative functions covering fire safety, safety programme, disaster plans and safe proper equipment disposal.	1. Adequate facilities, equipment and proper utilization of space within the Facility for all staff to carry out their related activities:						
	a. Facility Planning Utilization (FPU) Plan;						
	b. Adequate storage space including for BER equipment;						
	c. Appropriate tools and equipment to carry out related activities; and						
	d. Adequate report for the disposal procedures.						
CRITERION 3.4.1.2 (CORE)							
There is documented evidence that facilities and equipment in the Facility complies with relevant national/international standards and current statutory requirements.	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; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	5. Statutory, license and certificates of fitness.						
CRITERION 3.4.1.3 (CORE)							
Asset Management Program There is evidence that the Facility has a comprehensive maintenance programme such as planned preventive maintenance, predictive maintenance for critical life support equipment and calibration activities to ensure the facilities and equipment are in good working order, safe and effective. The maintenance programme and budget are reviewed.	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) report, based on performance data;						
	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;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	12. Electrical Safety Test & Performance Test; and						
	13. Routine Inspection.						
CRITERION 3.4.1.4							
Where high risk / specialized equipment and systems are used, there is evidence that only staff who are trained/ competent and authorized by the relevant bodies and management to operate and maintain such equipment.	1. List of high risk equipment and system;						
	2. List of personnel authorized by the Person In Charge (PIC) to operate specialized equipment;						
	3. Letter of authorization;						
	4. Training records;						
	5. Staff profile of authorized personnel;						
	6. Competency assessment records;						
	7. Utilization rate record of high risk equipment; and						
	8. Certificate/registration of competent person as required.						

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TOPIC 3.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 3.5.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 3.5.1.1							
There are planned and continuous 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; and e) Implementation of action plan.	1. Planned performance improvement activities include (a) to (e);						
	2. Records on performance improvement activities;						
	3. Minutes of performance improvement meetings; and						
	4. Quality Assurance Program.						
CRITERION 3.5.1.2							
The Head of Facility and Biomedical Equipment Management and Safety Services has assigned the responsibilities for planning, monitoring and managing building, equipment and system safety and performance improvement activities to appropriate individual/personnel within the respective services.	1. Minutes of meetings;						
	2. Letter of assignment of responsibilities; and						
	3. Job description.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 3.5.1.3							
The Head of Facility and Biomedical Equipment Management and Safety Services shall ensure 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/ Failure Mode Effect Analysis (FMEA) done and action taken within the agreed time frame to prevent recurrence.	1. System for incident reporting is in place, which include:						
		a. Training of staff;					
		b. Policy on incident reporting;					
		c. Methodology of incident reporting; and					
		d. Register/records of incidents;					
	2. Completed incident reports and statistics;						
	3. Root Cause Analysis/ FMEA;						
	4. Corrective and preventive action plans;						
	5. Remedial measure;						
	6. Minutes of meeting;						
	7. Acknowledgment by Head of Service and PIC/Hospital Director; and						
	8. Feedback given to staff regarding incident reporting.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 3.5.1.4 (CORE)							
The Head of Services shall identify minimum five (5) performance indicators for the services based on risk register endorsed by PIC. a) Percentage of planned preventive maintenance being done; b) Percentage of system/service uptime (Target: 92%); c) Response time: i) Response time to equipment failure (BEMS) (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); and e) Any two other indicators to be identified by the hospital.	1. List of performance indicators;						
	2. Performance indicators monitored; and						
	3. Records on tracking and trending analysis.						
	4. Remedial measures taken where appropriate.						
CRITERION 3.5.1.5							
Feedback on results of the performance indicators on safety of building, equipment and system and quality activities are regularly communicated to the relevant staff and hospital management.	1. Monthly report to Hospital Management;						
	2. Circulation list to Hospital Management, end user and engineering staff;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	3. Evidence of feedback via communication on results of quality activities through continuing education activities/meetings; and						
	4. Minutes of service/unit/committee meetings.						
CRITERION 3.5.1.6							
Appropriate documentation of safety of building, equipment and system and performance improvement activities is kept, and confidentiality is preserved.	1. Documentations on performance improvement activities and performance indicators; and						
	2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						

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TOPIC 3.6
SPECIAL REQUIREMENTS

STANDARD 3.6.1
BIOMEDICAL EQUIPMENT MANAGEMENT
The Facility is equipped with safe and functional medical equipment, operated and maintained including outsource services/loan equipment in a manner that supports the patient care objectives and compliance with regulatory requirements and safety of patients and staff.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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, associated Guidelines and MS 2058, MS 2650, MS 2739 or any other related standards, where applicable.	1. Relevant documents pertaining to Medical Device Act 2012 and MS2058, MS 2650, MS 2739 are available;						
	2. Evidence of medical devices/equipment procured from licensed establishment; and						
	3. Medical device registration certificate from Medical Device Authority.						
CRITERION 3.6.1.2 (CORE)							
Biomedical equipment user shall: a) ensure only biomedical equipment which has been maintained and approved by the authorized Biomedical Engineer / Facility Manager to	1. Manufacturer's manual availability;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
be operated and before used to the patient; b) Ensure biomedical equipment is used only for its intended purpose; c) Operate biomedical equipment in accordance with manufacturer manuals; d) Ensure appropriate user maintenance and calibration is performed; e) Not attempt repairs beyond the operating techniques described in the manufacturer manual; f) Replace equipment maintenance consumables as and when required; g) Be aware of conditions that may injure the patient or damage the biomedical equipment; h) Report for any malfunctions, damage and anomalies such as erratic meter responses, electrical flashing or arcing, or unusual sounds that may indicate malfunction in the system provided; i) Report biomedical equipment adverse and immediately cease to use any biomedical equipment and consumables involved in an incident and notify the relevant department; j) Routinely clean, dust and decontaminate biomedical	2. List of user training attended;						
	3. List of user maintenance consumables;						
	4. Report of erratic function that may indicate malfunction of medical devices;						
	5. List of adverse event and incident report;						
	6. Confirmation of decontamination procedures; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
equipment in compliance with local infection control policies; k) Properly place the active medical device during use, store and protect the biomedical equipment; and l) Record of biomedical equipment utilization.	7. Utilization record.						
CRITERION 3.6.1.3							
Llife cycle costs and utilization of biomedical equipment are reviewed and recommendations made for planned replacement of medical equipment inclusive of equipment categorized as Beyond Economic Repair (BER). Equipment's are upgraded and replaced in accordance with relevant statutory regulations. Any equipment exceeding their expected usage life span needs to be validated before being used by the user on the patient.	1. Records on Life Cycle Cost Analysis (LCC) programme;						
	2. Asset list for planned replacement;						
	3. Upgrading and replacement of biomedical equipment comply with statutory regulations as evidenced per records; and						
	4. Condition Appraisal report for equipment that have exceeded their usage life.						
CRITERION 3.6.1.4							
Operational and service manuals for biomedical equipment are current and accessible	1. Operation and service manuals for biomedical equipment are available, appropriate and related to the services.						
CRITERION 3.6.1.5							
New biomedical equipment including loaner equipment are checked for compliance with established standards prior to use	1. Operation and service manual is available;						
	2. Safety and performance test result;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	3. Records on testing and commissioning;						
	4. The terms of warranty is managed; and						
	5. Loaner equipment list.						
CRITERION 3.6.1.6 (CORE)							
Biomedical engineer shall ensure a list of biomedical equipment registry is maintained and updated, including identification of critical biomedical equipment, traceability of biomedical equipment and breakdown record.	1. Asset register is available and maintained;						
	2. List of critical equipment;						
	3. Tracking record on the location and usage of biomedical equipment; and						
	4. Breakdown report and record.						
CRITERION 3.6.1.7 (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; and e) proper calibration of test equipment as evidenced by certification.	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 3rd party or manufacturer; and						
	5. Vendors approved by relevant authorities.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 3.6.1.8							
Medical equipment breakdown repairs shall be recorded, prioritized and if parts required it shall use only genuine parts / OEM; repaired by a *competent person. Upon completion of repair; performance test and electrical safety test to be performed for active medical devices. OEM parts can only be used on the equipment that is not under manufacturer warranty or support. To ensure the use of Genuine parts, Biomedical Equipment Management shall: a) Survey all active medical devices and identify required spare parts; b) Source required genuine / OEM spare parts; and ~~c)~~ Shall maintain adequate inventory stock of required spare parts and practice good store management for critical equipment.	1. Repair service log;						
	2. Repair service reports;						
	3. Spare part list; and						
	4. List of competent persons to maintain the equipment.						
CRITERION 3.6.1.9 (CORE)							
Relevant licenses/certificates of fitness are acquired and kept current as required.	1. All licenses/certificates for equipment are current and complied with; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	2. Equipment used for Radiology/Diagnostic Imaging, Medical Laboratory and Nuclear Medicine have certifications from relevant agencies/authorities for operations.						
CRITERION 3.6.1.10							
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; and d) Properly installed, tested, commissioned, maintained, and disposed and e) The person using, operating, installing, testing and commissioning, maintaining and disposing of medical device shall have the qualification and competency as prescribed by the Minister in accordance to Medical Device Act 2012 (Act 737) and other relevant act.	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; and						
	6. List of authorized users for specialized / high risk equipment.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 3.6.1.11							
Head of Biomedical Equipment Management (BEM) is responsible for ensuring that the person maintaining any biomedical equipment are appropriately trained and qualified to carry out the work.	1. List of training schedule;						
	2. List of training assessment; and						
	3. Competency certificates.						
CRITERION 3.6.1.12							
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 please. A medical device shall be condemned or decommission if: a) BER; b) Obsolete; and c) Unavailability of spare part in the market. Medical device shall be disposed from the site within 6 month after issuance of the disposal certificate by the PIC.	1. Condition appraisal by qualified biomedical engineer/ vendor; and						
	2. Recommendation from users and/or technical experts on the ineffectiveness of any medical device.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 3.6.1.13							
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; and d) danger of it being re-used.	1. Plan/Programme for disposal of equipment is available;						
	2. Contractor/Vendor for the disposal programme is qualified and competent;						
	3. Disposal of radioactive related equipment comply with relevant agency/local authority requirements. i.e. Department of Environment (DOE), Atomic Energy Licensing Board (AELB); and						
	4. Disposal records.						
CRITERION 3.6.1.14							
The Biomedical Engineering Service shall assist the Facility with the planning and inclusion of new medical equipment and replacement of existing equipment.	1. Records on advice/consultation between the Facility Management and the Biomedical Engineering Services. Inventory list of new and replaced biomedical equipment.						
CRITERION 3.6.1.15							
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.	1. Annual Medical Equipment Management Programme Performance Evaluation Report.						
	2. Records on performance indicators and audits; and						
	3. Continual improvement project record/report.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 3.6.1.16							
Action taken on field safety notice (FSN)/field safety corrective action (FSCA)/recall issued if any by Medical Device Authority or manufacturer and documented.	1. Recall notice if any and evidence of compliance; and						
	2. Action taken on safety notice issued by any authority.						
CRITERION 3.6.1.17							
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.	1. Designated area for cleaning within the biomedical equipment workshop; and						
	2. Procedure for cleaning in place and being practiced.						

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STANDARD 3.6.2
FACILITY MANAGEMENT
The Facility shall be designed, 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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Facility is managed by certified Healthcare Facility Manager;						
	2. Planned Preventive Maintenance (PPM) schedule (Plan and Actual);						
	3. Contract agreements for outsourced services; and						
	4. Job Sheet/Maintenance report.						
CRITERION 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.	1. Competent person with qualification and certification from relevant authority works on designated facilities and equipment e.g., lifts, medical gas, ACMV, charge man.						
CRITERION 3.6.2.3							
The healthcare and related facilities shall request for competency training from approved manufacturer or approved 3rd party training centre.	1. Records on request for competency training programme;						
	2. Attendance list and training records; and						
	3. Training certificate must be verified and endorsed by 3rd party.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Availability of appropriate tests equipment; and						
	2. Validity of calibration certificate.						
CRITERION 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.	1. Maintenance and inspection records history.						
CRITERION 3.6.2.6 (CORE)							
Life cycle costs and utilization of buildings and plants are reviewed and recommendations made for planned replacement of building and facilities. Building and facilities are upgraded and replaced in accordance with relevant statutory regulations.	1. Records of building facilities inspections with the Life Cycle Cost Analysis (LCC) programme on facilities;						
	2. Records on upgrading and replacement of the comply with statutory regulations; and						
	3. Asset list for planned replacement.						
CRITERION 3.6.2.7							
Drawings and operational manuals for plants and equipment are current and accessible.	1. Drawings and operation manuals for plants and equipment for related services are:						
	a. available; and						
	b. properly kept.						
	2. Drawings are endorsed by Professional Engineer; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	3. Relevant as-built drawing/ single line drawing shall be clearly displayed on the wall of all engineering plant rooms and service areas.						
CRITERION 3.6.2.8							
New/replaced plants and equipment are checked for compliance with established standards prior to use.	1. Verification plant room area;						
	2. Compliance of plants and equipment with relevant standards and regulations;						
	3. Record in asset registration; and						
	4. Safety and performance test result.						
CRITERION 3.6.2.9							
An asset register of plants and equipment is maintained.	1. Asset register is maintained.						
CRITERION 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; and f) Proper calibration of the testing and measurement tool by certified calibration laboratories as evidenced by certification.	1. Documented maintenance programme is available;						
	2. The maintenance schedule follows the manufacturer/ suppliers' specifications and/or relevant authorities' regulation; and						
	3. The calibration report of test tool to be conducted by certified calibration laboratories.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 3.6.2.11 (CORE)							
Relevant licenses/certificates of fitness are acquired and kept current as required (e.g., lift/ any pressured vessel according to DOSH requirements)	1. All licenses/certificates should be current and complied with.						
CRITERION 3.6.2.12							
Safety stores, cold rooms and plant rooms are equipped with self-closing doors or safety latches, where appropriate	1. Installation of self-closing doors and/or safety latches for stores, cold rooms, plant rooms etc.						
CRITERION 3.6.2.13							
Signs throughout the Facility are clearly displayed, and easy to follow (for example, directional and safety signs, exits, and isolation areas).	1. Able to find the specific locations without asking.						
	2. Appropriate signs are available and displayed clearly.						
CRITERION 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 licenses.	1. Policies on the use and maintenance of motor vehicles used for staff and patients;						
	2. Validity of drivers' licenses; and						
	3. Vehicles maintenance record.						

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STANDARD 3.6.3
BUILDING REQUIREMENTS
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.

a) Building- Roof Top;
b) Ceiling Height;
c) Entrances and Exits;
d) Windows; and
e) Doors.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 3.6.3.1 (CORE)							
Building - Roof Top 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.	1. On-site inspection shows:						
	a. Roof top has no water ponding and plant growth; and						
	b. No leaks spotted from the roof.						
	2. Waterproofing warranty for flat roof.						
CRITERION 3.6.3.2							
Ceiling Height 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; and c) 2.7 metres minimum clear floor to ceiling height in operating rooms, labour	1. Design and height of the ceiling for specific rooms/locations comply with relevant requirements as listed in (a) to (c).						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
delivery rooms and similar rooms having special ceiling-mounted light fixtures.							
CRITERION 3.6.3.3 (CORE)							
Ceiling Type Design of the ceiling in critical areas such as isolation room, Endoscopy Suite (Bronchoscopy), microbiology room, Sterile Store, operating theatre, Cath Lab, Intensive Care Unit comply with specific requirements, i.e. seamless type.	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.						
CRITERION 3.6.3.4							
Entrances & Exits a) Entrances and exits in the facility shall be located in an area where minimum disturbance is caused to patients. The entrance for patients and visitors of the facility shall be adjacent to the lobby; b) There shall be at least one entrance designed without stairs for the movement of patients in wheelchairs or on stretchers within the facility or service; c) There shall be separate entrances for emergency patients, service personnel, and patients and visitors; d) The emergency patient entrance shall be located for ready access to the emergency department or unit	1. Building design shows entrances and exits comply with requirements listed (a) to (g) upon inspection; and						
	2. Entrances and exits to the buildings comply with the requirements of relevant authorities i.e. fire authority.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
and easily accessible to pedestrians, ambulances, and other vehicular traffic; e) The service entrance shall be located close to storage rooms or areas, elevators, and the kitchen; f) There shall be a dedicated exit for the unobtrusive removal of deceased bodies; and g) The entrances shall be equipped with mechanisms to prevent the ingress of hot and humid outside air into the building to reduce the risk of surface condensation.							
CRITERION 3.6.3.5							
Windows Windows are required in all patient rooms except labour delivery rooms. Windows allow for unobstructed natural lights.	1. Presence of windows in all patient care rooms except in Labour Delivery Suites. Verified upon inspection.						
CRITERION 3.6.3.6							
Doors 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.	1. Policies and documented instructions on access and egress to patients' rooms; and						
	2. Doors to patients' rooms found not locked from the inside as per policy upon inspection.						
CRITERION 3.6.3.7							
Patients' toilet door to be open outward but not to obstruct main corridors.	1. Patients' toilet door open outward as per regulation.						

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STANDARD 3.6.4
EXTERNAL FACILITIES
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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; and c) Drains and manholes are not clogged and properly covered.	1. Visual inspection shows clean estate grounds as listed (a) to (c); and						
	2. Maintenance records.						
CRITERION 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; and						
	3. Plan and provision to cater for insufficient parking space to patient and visitors.						

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STANDARD 3.6.5
SEWAGE AND SEWERAGE SYSTEM
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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Inspection and checking of the as built drawing shows no exposed sewer lines over critical clinical and support services areas.						
CRITERION 3.6.5.2							
Affluent test is to be conducted every six months.	1. Competent person with qualification and certification from relevant authority works on designated facilities and equipment e.g., lifts, medical gas, ACMV, charge man.						
CRITERION 3.6.5.3							
There shall be a competent operator available to manage the sewage treatment plant as required under the Drainage and Sewerage Act.	1. Compliance with National Water Services Commission (Suruhanjaya Perkhidmatan Air Negara, SPAN) regulation; and						
	2. The contractor doing the maintenance work is qualified and registered with SPAN.						
CRITERION 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	1. Piping system connected to STP as observed upon inspection; and						
	2. As built drawing of facility and piping system.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
or municipal sewage treatment plant.							
CRITERION 3.6.5.5							
The Sewage System shall be properly maintained. There shall be no waste water and sewage overflow to open environment.	1. Maintenance reports on STP; and						
	2. Visual checking of the piping system.						

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STANDARD 3.6.6
MECHANICAL SYSTEM - AIR CONDITIONING AND VENTILATION SYSTEM

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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Comply with the requirements of the relevant Acts, statutory requirements, and local building codes.						
CRITERION 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.	1. Records on monthly inspection of cooling towers;						
	2. Results on test on Legionella bacteria done every six (6) months; and						
	3. Regular water quality test results.						
CRITERION 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.	1. Evidence of standby/backup chiller as required; and						
	2. As built drawings.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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	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; and						
	d. filter inspection done regularly.						
	2. Maintenance records.						
CRITERION 3.6.6.5							
Air handling units, fan coil units, exhaust fans, and piping systems are maintained and checked regularly.	1. Maintenance records; and						
	2. Visual checking of the piping system.						
CRITERION 3.6.6.6							
Ventilation a) All rooms and areas shall be adequately ventilated with minimum six (6) air change per hour; 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, odors or contaminants originate;	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); and						
	3. Evidenced as per built drawings.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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 odors (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 centralized 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;							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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, labor-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; 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; and 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							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and iv) Able to deliver air to meet air cleanliness by particle concentration of BS EN ISO 14644-4 2015, ISO Class 7 for OT 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							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and vi) Ante room shall be provided with a 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; and ii) Maintain a positive pressure relative to air pressure of adjacent areas. n) In critical services areas such as operating theatres, sterile store, Central Sterilizing Supply Unit, Intensive Care Unit, High Dependency Unit,							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Neonatal Intensive Care Unit, Isolation Room, Special Care Nursery, Microbiology Laboratory and Pharmacies the air distribution shall be ducted type for the supply and exhaust system; and o) Endoscopy suite (bronchoscopy) shall maintain a negative pressure and the washing area to be equipped, exhausted and filtered safely to the open environment.							

STANDARD 3.6.7
INDOOR AIR QUALITY

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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 3.6.7.1							
Indoor Air Quality (IAQ) 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	1. Annual Monitoring/mapping IAQ report is available;						
	2. Audit report on compliance to performance standards is available; and						
	3. No visible fungal or mold growth seen especially at critical patient care areas and indoor surfaces.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
performance standards and requirements; and d) Perform remediation actions on identified indoor air quality and indoor surface condensation issues.							

STANDARD 3.6.8
MEDICAL GASES

Medical gas supply includes delivery of oxygen, nitrous oxide, active anesthetic 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 with compliance with HTM 0201/ MS 2675.

The safety of all Medical Gas System is dependent on four (4) basic tenets:

a) Identification;
b) Adequacy;
c) Continuity; and
d) Quality of supply.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 3.6.8.1							
Standard compliance Medical Gas System (MGS) installation shall comply with Medical Device Act (MDA) (Act 737), Private Healthcare Facilities and Services (PHFS) Act, MS	1. As Built Drawing of the system certified by Authorized Engineer/Professional Engineer;						
	2. Testing and commissioning report witnessed by competent person; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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 Authorized Person and approved by relevant authorities.	3. Department of Occupational Safety and Health (DOSH) PMT certificates.						
CRITERION 3.6.8.2 (CORE)							
Competencies All staff handling Medical Gas System (MGS) has to be competent. There must be an Authorized Person to supervise and manage medical gas system operation and maintenance. Regular training shall be done in compliance to the standard regulatory requirement for all staff handling medical gases conducted by an accredited training provider. All trained staffs should have satisfactory completion of certificates with validity.	1. Competency Certificate of Competent Person and Authorized Person;						
	2. Nursing and facility management staff certificate of training records; and						
	3. Porters (BPD) / Trained staffs who understands the potential hazard (Porters).						
CRITERION 3.6.8.3							
Plant Room (Source of Supply) a) Oxygen supply: i) VIE; and ii) Manifold System. b) Medical Air / Surgical Air: i) Air plant compressor system; and ii) Manifold System. c) Manifold System:	1. Compliance to standard requirements of MGS plant room; and						
	2. Verification upon inspection.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
i) Nitrous oxide / Entonox; and d) Vacuum Plant System: i) Plant System. e) Anaesthetic Gas scavenging plant system Plant system room shall be dedicated and no other materials are allowed in these rooms. It shall be well-ventilated, properly and labelled for each service. Cylinders shall be well segregated as Full, Empty and Defect with by means of adequate labelling systems that clearly indicates the cylinder status. Local storage (Wards) Cylinders shall be mounted on trolleys are used as emergency gas supplies in ward areas. All nursing staffs should be made aware of the location and cylinder conditions with proper segregation.							
CRITERION 3.6.8.4							
Fire Precautions Smoke or heat detector should be installed in Plant system, medical gases manifold rooms and medical gas stores with an automatic fire detection system with fire code (BOMBA) guideline. Precautions to be applied where there may be a risk of ignition due to the presence of flammable materials of gas or vapors mixed with a or under normal atmospheric condition.	1. As built drawings; and 2. Verification on inspection.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Room should be free from naked flames / sparks and all should be designated as No smoking areas Appropriate fire fighting equipment should be provided within the room or at convenient location nearby. Ventilation louvers should be provided for all manifold rooms and plant rooms. An ambient temperature of manifold room and plant rooms should be maintained within the range of 35 – 40 degrees Celsius.							
CRITERION 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 with a minimum time delay to changeover or with UPS system at critical departments only. All electrical wiring should be in accordance with IEE regulations.	1. As built drawing; and 2. Verification on inspection.						
CRITERION 3.6.8.6							
Identification a) All pipe needs to have proper labelling of specific gas; color 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	1. Verification on medical gas safety requirements as listed (a) to (f) through site inspection.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and f) The cylinders valves to be pin index type.							
CRITERION 3.6.8.7							
Source of Supply (Adequacy & Continuity) **<u>Cylinder Manifold System</u>** Oxygen, Nitrous Oxide, Entonox, Medical air/ Surgical air is supply should consist of Primary supply, Emergency reserve supply as follows: a) The primary supply shall be of an automatic manifold changeover from duty to standby should either one side goes empty; b) Each bank of the manifold should have sufficient cylinders for two days supply, additional cylinders for one	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 Authorized 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; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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complete bank change should be held in the manifold room as spare. Sufficient cylinders to change two banks should be in place; c) All replenishment cylinders shall be recorded in the log book, if each bank change is less than two days for a bank cylinders, then provision to increase the number of cylinders shall be done; d) Additionally, an emergency reserve supply manifold with sufficient cylinder capacity connected to supply for four hours shall be in place; e) Bulk Liquid Oxygen (VIE) for oxygen can be used as a primary supply and the secondary supply system should be a fully automatic changeover gas cylinder manifold that's comes into operation automatically; f) The secondary cylinder supply sources can be as 10 cylinders of each capacity to support VIE system; g) Medical air / Surgical Air can be supplied by Oil free compressors plant system; h) Additionally, an automatic manifold system is essential to be connected as an emergency supply in the event that primary medical air plant supply system failure; and	5. A risk assessment report on the MGS installation showing that the risk of interruption to medical gas supply is low.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
i) The capacity with number of cylinders hall be ability to provide at least for 4 hours of supply at average use.							
CRITERION 3.6.8.8							
Vacuum Insulated Evaporator (VIE) System for Oxygen The liquid oxygen supply is the primary supply which is normally selected to provide for at least 14 days consumption or subjected to risk assessment by an Authorized Person/ Professional engineer, gas supplier and facilities management. An emergency back-up supply equipment 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 delivery in place.	1. Calculation on oxygen consumption report by the authorised person / professional engineer;						
	2. Risk assessment report by the authorised person/ professional engineer; and						
	3. Maintenance record.						
CRITERION 3.6.8.9							
The VIE vessel shall be approved by Department of Occupational Safety and Health (DOSH) and registered with Medical Device Authority (MDA).	1. PMT certificate; and						
	2. PPM report record.						
CRITERION 3.6.8.10							
The VIE tanks shall be fenced off. Adequate warning signage shall be posted on the fence. No vehicles or	1. Site inspection on compliance HTM 0201/MS 2675:2017;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
unsafe activities to be carried out within the distances as per HTM 0201/MS 2675:2017 standards guideline. Alarm monitoring system should be fitted with alarm indication for visual and audible at VIE compound and with 24 hours man station.	2. Alarm monitoring system configuration; and						
	3. Safety signages.						
CRITERION 3.6.8.11							
For non-critical care areas where there are no high dependency patients, it may be appropriate to use individual cylinders as the reserve source of supply with cylinders fitted with integral and having a gas specific connection suitable for this purpose.	1. As built drawing;						
	2. Verification on inspection; and						
	3. Safety signages (Emergency supply in use).						
CRITERION 3.6.8.12 (CORE)							
Warning and Alarm System The provision of alarm monitoring system essential to monitor the safe and efficient operations of MGPS. **Plant Monitoring System** At 24 hours Medical Gas monitoring alarm system shall be installed at the staff occupation area. (e.g. control room) and at dedicated source plant room locations in order to monitor individual source plant system. Repeater alarm panel should be provided in other locations to	1. Records on testing and PPM services;						
	2. Verification on inspection of the Medical Gas Alarm Panel – (Simulation test) record; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
display so that continues monitoring remains. Area alarm warning Local alarms / area alarm to display "HIGH" and "LOW" should be installed at the downstream of designated AVSU for each specific gas services.	3. Labelling of all visual and signal panel accordingly to their functions.						
CRITERION 3.6.8.13							
Quality of Gas Supply a) The supplier of medical gas shall ensure the quality of medical gas supply complies with the National Pharmaceutical Regulatory Agency (NPRA) and European Pharmacopoeia (Ph.Eur) monogram, MS 2675-2017 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; and d) Regular PPM services shall be carried.	1. Latest quality certificates of the medical gas supplier; and						
	2. Testing and Commissioning reports; and.						
	3. Labelling of all visual and signal panel according to their functions.						
CRITERION 3.6.8.14 (NEW)							
Operational policies Operational policies for medical gas systems should be established based on compliance standards (HTM 02-01/MS 2675:2017), with	1. Record of training; and						
	2. Record of Permit to Work (PTW) issued.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
clear roles, risk-based action plans, competent personnel, and defined procedures for emergency response, maintenance, and alarm management to ensure patient safety.							

STANDARD 3.6.9
MEDICAL AIR SYSTEM

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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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; and d) Medical air supply design must ensure air purity and operational reliability.	1. Verification upon inspection;						
	2. PMT certificate; and						
	3. As Built Drawing to be endorsed by professional engineer.						

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STANDARD 3.6.10
VACUUM SYSTEM
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Verification on inspection						
	2. Records on regular replacement of filters to the suctions						

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STANDARD 3.6.11
ACTIVE ANAESTHETIC GAS SCAVENGING SYSTEM

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. Active anesthetic Gas Scavenging Systems (AGSS) enhances the safety of the environment in which members of the staff are in close proximity with waste anesthetic gas.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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 anesthetic Gas Scavenging System (AGSS) shall be made available.	1. As built drawing; and						
	2. Verification on inspection.						

STANDARD 3.6.12
VERTICAL TRANSPORT SYSTEM

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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 3.6.12.1							
a) There is a certificate of fitness to verify that elevators comply with requirements of the Department of Occupational Safety and Health; and b) The number and size of the elevators comply with the requirements of the Private Healthcare Facilities and Services Act (PHFSA) 1998	1. Valid and current certificate of fitness;						
	2. Yearly license 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. And Fire Service Services Act 1988;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and iv) For transfer of patient-bed with attachments, the size of such elevators are appropriate to such function.	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); and						
	5. Records on maintenance and inspection.						

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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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Minimum storage of 48 hours water supply; and						
	2. Verification of as built drawing for cold water system for kitchen, suction tank, storage tank.						
CRITERION 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.	1. Results of water sampling test from the approved body.						
CRITERION 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.	1. Visual check on the piping system; and						
	2. Hot and cold water piping as built drawings endorsed by Professional Engineer.						
CRITERION 3.6.13.4							
Drinking water storage tanks (if available) are secured and inspected monthly to ensure they	1. Maintenance reports on water storage tanks, i.e.log book on inspection;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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).	2. Report on the cleaning of storage and suction tanks; and						
	3. Reports on water analysis.						

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STANDARD 3.6.14
ELECTRICAL SYSTEM – GENERAL COMPLIANCE

The general compliance to the electrical system covers the following aspects in the Facility:

a) Electrical Supply;
b) Electrical Distribution Scheme;
c) Electrical Standby Generator;
d) Uninterrupted Power Supply System (UPS);
e) Illuminations and Light Fittings; and
f) Switch Socket Outlets.

The electrical system of the Healthcare Facility shall be adequately sized and comply with Act 586 and MS IEC 60364 to cater for the services requirements.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 3.6.14.1							
Electrical Supply 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	1. As Built Drawings on the electrical system;						
	2. Appointment of Competent Electrical Engineers, charge-man, wiremen; and						
	3. Letter of appointment and credentials of electrical engineer and charge- man including competent personnel certification from National Energy Commission.						
CRITERION 3.6.14.2							
Electrical Distribution Scheme Normal, essential and uninterrupted power supply shall be provided in hospital facilities	1. Verification of evidence as endorsed from as built drawing; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
accordance to requirement and criticality of service requirement.	2. Electrical single line diagram endorsed by Professional Engineer.						
CRITERION 3.6.14.3 (CORE)							
Electrical Standby Generator 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, labor-delivery	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. Verification as evidenced through inspection;						
	8. As built drawings;						
	9. Verification by inspection;						
	10. Relevant test reports; and						
	11. Dedicated electrical board for emergency power supply is available and clearly labelled.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Rooms, emergency rooms, recovery rooms, laboratory, blood bank locations, medicine dispensing areas, radiology and radiographic rooms, mortuary freezers; and 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; 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; and 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; and							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.							
CRITERION 3.6.14.4 (CORE)							
Uninterrupted Power Supply System (UPS) a) Uninterrupted power supply (UPS) shall be provided for life support systems, essential lights in operating theatres and rooms for interventional procedures; 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; and c) Adequate UPS also shall be provided to the following: i) Public Address/Fireman Evacuation Announcement System; ii) Nurse Call System; and iii) IT server room.	1. Endorsed as built drawing i.e. for UPS and power supply for Nurse Call system;						
	2. Periodic maintenance records; and						
	3. Verification through actual site inspection.						
CRITERION 3.6.14.5							
Illuminations and Light Fittings a) The level of illuminations shall meet the MS 1525;	1. Lighted areas and level illuminations meet MS 1525;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and d) Night light shall be properly located in each patient room and at proper intervals in corridors in nursing unit. 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.	2. Energy audit reports; 3. Evidence through actual site inspection; and 4. Endorsed as built drawings.						
CRITERION 3.6.14.6							
Switch Socket Outlets a) Nature of electrical sockets. 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,	1. Policy on the use of telecommunication device; and 2. Signage on the prohibition of use of telecommunication device.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
uninterrupted power supply (UPS) and emergency power supply and coded according to international standards; and **Notes/Explanations:** International color codes for switch socket outlets: i. Normal local supply – white; ii. Uninterrupted power supply (UPS) – yellow; iii. Emergency power supply (EPS) – red; and c) There shall be adequate number of electrical sockets connected to an emergency power source: i) Located in operating theatres, nursery, labour-delivery rooms, emergency room and all intensive care units suitable for the services to be performed; ii) Located at the head of each bed in patient rooms, labour-delivery rooms, recovery rooms and all intensive care units; iii) In all nursing units; iv) For critically needed equipment in all patient care areas;							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
v) For refrigerators for biologicals; vi) For x-ray illuminators in each operating theatre room and emergency room; vii) The sockets shall not be used other than for patient care purposes.							
CRITERION 3.6.14.7							
Voltage stabilizers shall be provided in areas where high precision equipment is located.	1. Voltage stabilizers available where required;						
	2. Endorsed as built drawings; and						
	3. Evidenced through actual site inspection.						
CRITERION 3.6.14.8							
Surge protection devices (SPDs) shall be provided for the main electrical distribution system including sub-witchboards and distribution boards, computers, electronic equipment, etc. which are susceptible to lightning and switching surges; in Adequate quantity.	1. Surge protection devices available where required; and						
	2. Evidenced through actual site inspection.						
CRITERION 3.6.14.9							
Use of Telecommunication Device a) The use of telecommunication devices shall not be permitted within critical care units, operating theatre and any other room or area where the	1. Policy on the use of telecommunication device.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.	2. Signage on the prohibition of use of telecommunication device.						
CRITERION 3.6.14.10 (CORE)							
Maintenance 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 authorized personnel.	1. Scheduled maintenance shall follow recommendations from manufacturer/supplier/installer.						
	2. Records on maintenance and evidenced through as built drawings						

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STANDARD 3.6.15
ELECTRICAL SYSTEM – CRITICAL AREAS

The electrical system for critical areas covers as follows but not limited to:

a) Operation Theatres;
b) Critical Care Area (Intensive Care Unit, High Dependency Unit, Cardiothoracic Intensive Care Unit, Cardiology Care Unit, NICU & PICU);
c) Isolation Room;
d) Central Sterile Supply Department;
e) IT Server Rooms;
f) Microbiology laboratory; and
g) Blood Bank.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 3.6.15.1 (CORE)							
a) Installation of Isolated Power Supply System (IPS is mandatory for the following locations: i) Operating Theatres and anesthetic Induction Rooms; ii) Critical Care Units including ICU, NICU, etc; iii) Emergency Resuscitation Room; iv) Cath Lab; v) High Dependency Unit; vi) Electrophysiology/ Interventional Lab; vii) Post Anesthesia Care Unit; viii) Endoscopy Suite; and ix) Burn Unit. b) Isolated Power Supply System (IPS) is designed that: i) The department shall be facilitated with adequate	1. Endorsed as built drawing;						
	2. Periodic maintenance records; and						
	3. Evidenced upon actual site inspection.						

DISTRIBUTION

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Insulation Monitoring Device (IMD) OR Line Isolation and Overload Monitoring Device (LIOM) an integral part of Isolated Power Supply System (IPS); and ii) The system shall be used and maintained properly with proper documentation.							
CRITERION 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; 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	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; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
reception counter and control room which will be triggered when the system is not charged; and d) A UPS shall also be provided for Nurse Call System.	4. Evidenced through actual site inspection.						
CRITERION 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; and b) Emergency power supply system shall also provide the illuminations for exit signage, emergency lights, and nurse stations.	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; and						
	5. Evidenced upon actual site inspection.						
CRITERION 3.6.15.4							
The number of electrical sockets ensures that:	1. Endorsed as built drawing;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
a) No adaptors, extension cords and junction boxes shall be permitted in any room or area; and b) There shall be adequate number of electrical sockets	2. Periodic maintenance records; and						
	3. Evidenced upon actual site inspection.						

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STANDARD 3.6.16
ENERGY MANAGEMENT

The Facility is planned with an 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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 3.6.16.1							
There is an energy management programme in place compliance to Energy Efficiency and Conservation Act (EECA) 2024 and includes the following: A registered energy manager shall be appointed by the facility if the Facilities consuming 21,600 GigaJoule period of twelve consecutive months with advanced qualifications required if consumptions exceeds 50,000 GJ/year under the Energy Efficiency and Conservation Regulations 2024. The facility may appoint an external Registered Energy Manager (REM) for up to three years, after which an internal REM must be appointed in compliance with national energy regulations. The Sustainable Energy Management Committee shall be established to carry out the following activities with the involvement of the Energy Manager: a) Establish policies and procedures, support the energy management committee to implement,	1. Appointment of Registered 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; and						
	5. Minutes of Sustainable Energy Management Committee.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
maintain and continually improve the effective usage of electrical energy in accordance with the regulatory requirements; b) Identify, perform, set up energy targets, plan and manage the energy consumption through the Sustainable Energy Management Programme (SEMP); c) Conduct technical audits that include financial evaluation for energy conservation measures; and d) The energy management programme complies with regulatory requirements and should not compromise the safety and comfort of patients and staff.							

STANDARD 3.6.17
CONNECTIVITY
The facility is equipped with secured and effective connectivity of high speed WIFI services.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 3.6.17.1							
Connectivity means being in the quality of stable, state or capability of being connective.	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						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	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; and						
	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.						

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SERVICE SUMMARY	
-	
OVERALL RATING :	-
OVERALL RISK :	-

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SERVICE STANDARD 04: NURSING SERVICES

PREAMBLE

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. The Nursing Services shall be organized, directed and coordinated with the other services in the Facility to provide nursing care in a safe, efficient, effective and caring manner.

TOPIC 4.1
ORGANISATION AND MANAGEMENT

STANDARD 4.1.1

The Nursing Services shall offer a high standard of care to the community, as outpatients and inpatients in a safe, effective, efficient and caring manner; and shall be organized, directed and coordinated with the other services in the Facility.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of critical nursing services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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	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 are measurable 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); and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
and revised as required accordingly and communicated to all staff.	4. Achievement of goals and objectives are monitored, reviewed and revised accordingly.						
CRITERION 4.1.1.2 (CORE)							
The organizational structure of the Nursing Services is clearly represented in one or more organization 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) organization; ii) functions; iii) reporting relationships; iv) Staffing patterns.	1. Clearly delineated current organization 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 organization chart is available which reflects the working relationships between consultants, medical practitioners and staff of the Nursing Services;						
	3. Organization chart of the service is endorsed, dated and accessible; and						
	4. The organization chart is revised when there is a major change in any of the items (c)(i) to (iv).						
CRITERION 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,	1. Minutes are accessible, disseminated and acknowledged by the relevant members.						
	2. Attendance list of members with adequate representation of the service.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
communicated to relevant members of the service and implemented.	3. Frequency of meetings with agenda as scheduled.						
	4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).						
CRITERION 4.1.1.4							
The Head of Nursing Services is involved in the planning, justification and management of the budget and resource utilization of the services.	1. Minutes of Facility-wide management meeting;						
	2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc.) for the service; and						
	3. Approved budget and resources.						
CRITERION 4.1.1.5							
The Head of Nursing Services is involved in the appointment and/or assignment of staff.	1. Records on staff interview (if applicable);						
	2. Appointment/assignment letter;						
	3. Job descriptions specific to the unit;						
	4. Records on staff deployment; and						
	5. Duty roster.						
CRITERION 4.1.1.6							
Appropriate statistics and records shall be maintained in relation to the	1. Records are available but not limited to the following:						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
provision of Nursing Services and used for managing the services and patient care.	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; and						
	e. Annual report to Governing body.						
CRITERION 4.1.1.7							
The Head of Nursing Services is responsible in planning, development and evaluation of nursing facilities and services.	1. Involvement of Nursing Ward Managers and HOS (where applicable) in the planning, development and implementation of new policies, facilities, and services; and						
	2. Minutes of meeting.						
CRITERION 4.1.1.8							
There is evidence that the Nursing Services are involved in the development and implementation of new technologies.	1. Involvement of the nursing staff on development and implementation of new technologies; and						
	2. Minutes of departmental/management meeting.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 4.1.1.9 (NEW)							
The Head of Services shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	1. Documented and approved BCP for unanticipated situations;						
	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment.						
	3. Clear actions and staff responsibilities during disruption;						
	4. Record of drills or tests, with follow-up actions, if conducted; and						
	5. Review of Risk Register.						
CRITERION 4.1.1.10							
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: d) Time period; e) Liability; f) Review of terms of contract; and g) Accountability for clinical nursing practice.	1. Valid Memorandum of Understanding (MOU) or Agreement;						
	2. Ratio of Clinical Instructor (CI) and students commensurate with the number of student (1:15); and						
	3. Student ward allocation roster.						

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TOPIC 4.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD 4.2.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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. 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 Practicing 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; and						
	5. Deployment/assignment according to staff experience and specialty training.						
CRITERION 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.	1. Valid appointment letters and Terms of Reference as member of committees stipulated by the Governing Body; and						
	2. Minutes of relevant committee meetings.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Designated registered nurses are assigned to each unit with delegated responsibility for management of Nursing Services;						
	2. Letters of appointment;						
	3. Job descriptions specific to the unit; and						
	4. Duty roster.						
CRITERION 4.2.1.4							
The assessment, planning, implementation and evaluation of nursing care is the responsibility and accountability of each and every registered nurse.	1. A structured approach should be adopted to ensure nursing care with comprehensive personalised focus on each patient's needs as stipulated in Standard 4.3.1.9.						
CRITERION 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;	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:						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
iii) Experience of the various categories of nursing staff. c) Contingency staffing plan (absenteeism, turnover etc.).	a. Full time staff (Infection Control Nurse) in accordance with national norm commensurate with bed occupancy rate;						
	b. Current assigned duty roster;						
	c. Patient acuity level of care;						
	d. Not more than 20% trained nurses with less than 1 year working experience;						
	e. All trained nurses shall have the competency performance level of 75% and above;						
	f. Written contingency plan for turnover and absenteeism; and						
	g. Documented staff deployment.						
CRITERION 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	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 specialization skills;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and v) Statutory Regulations. e) Administrative, teaching and clinical functions.	3. Relevant privileges granted where applicable (especially for multidisciplinary wards); and						
	4. The job description is acknowledged by the staff and signed by the Head of Service/Unit and dated.						
CRITERION 4.2.1.7 (CORE)							
There is a structured orientation programme for all newly appointed, contracted and outsourced staff to the nursing service that include but not limited to the following: <u>General</u> a) Vision and mission of the Facility; b) Organization chart and reporting structure of the Facility; c) Environment and facility safety policies and procedures including sustainability practices; d) Infection control policies and procedures; e) Policies for performance management, patient safety	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 (q); and						
	3. Attendance list.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
(IPSG/MPSG) and risk management; f) Ethical practices and code of conduct including medicolegal awareness; g) Management of aggression, violence and harassment; and h) Patient and family rights. <u>Services</u> i) Goals, objectives and organizational structure of Nursing Services; j) Policies and procedures relevant to Nursing Services; k) Working instructions for patient care; and l) Service continuity plan for Nursing Service in response to internal and external disasters. <u>Job-specific</u> m) Explanation of particular duties and functions. n) Explanation of the methods of assigning clinical care and the standards of clinical practice. o) Handover communication. p) Training in basic/advanced life support techniques; and q) Technology and equipment use including artificial intelligence, digital care and robotics							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 4.2.1.8							
Staff receive evaluations of their performance at the completion of the probationary period and annually.	1. Performance appraisal for staff is completed upon probationary period and as an annual exercise.						
CRITERION 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.	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; and						
	5. Evidence of staff capacity building assessment being monitored.						
CRITERION 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.	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; and						
	4. Certificate of attendance/degree/post basic training						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Staff personal records include:						
	a. Staff biodata;						
	b. Qualification and experience with primary source verification where applicable;						
	c. Evidence of current registration;						
	d. Training record;						
	e. Competency record and privileging;						
	f. Leave record; and						
	g. Confidentiality agreement.						
CRITERION 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.	1. Skilled Clinical Nursing Instructors with student ratio are appropriately met (1:15);						
	2. Written evidence to prove 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;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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	4. Signed Code of Conduct by Clinical Instructor; and						
	5. Minutes of joint meeting between the Nursing Services with the Nursing College.						
CRITERION 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 e) Area of competence; and f) The granting of privileges is approved by the Credentialing and Privileging Committee and certified by	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; and						
	4. Formal letters of assignment or certificate of privileging with stipulated timeline are issued and reviewed accordingly.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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the Person In Charge (PIC) / Governing Body.							

STANDARD 4.2.2 (NEW)

The nursing services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the nursing staff, ensuring a safe and healthy work environment.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 4.2.2.1 (CORE)							
The nursing services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being: a) A health-promoting environment, e.g., stress management, burn out, staff engagement opportunities, workload monitoring, management of work life balance, healthy, lifestyle programmes e.g. Workplace Wellness Programs, Community-Based Health Initiatives; b) Staff shall be provided with appropriate supervision, support, and advice e.g., mentor mentee program; and c) There shall be clear procedures for the effective management of underperformance e.g., feedback on performance	1. The promotion of staff well-being may involve the following:						
	a. Evidence of a health promoting environment e.g., workplace wellness programme;						
	b. Evidence of proper supervision of staff;						
	c. Evidence of staff appraisal programme with feedback on underperformance.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
review or performance appraisal report.							
CRITERION 4.2.2.2 (CORE)							
The nursing services shall establish a safe mechanism for nursing staff to express grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety.	1. Nursing staff suggestions and grievance reporting and processing mechanisms are available;						
	2. The resolution of workplace issues may involve the following:						
	a. Measures and evidence of nursing staff protection including whistleblowers against violence, bullying, and harassment e.g., awareness campaigns, anonymous reporting channel, Whistleblower policy; and						
	b. Documented policies and procedures for violence activation and nursing staff protection.						
CRITERION 4.2.2.3							
A system shall be created to gather nursing staff feedback about their workplace experience such as burnout which shall be analysed and used to make improvements that enhance the work environment, nursing staff satisfaction, and organisation culture.	1. Nursing staff feedback (e.g., minutes of sessions or nursing staff satisfactions survey);						
	a. Evidence of action or improvement taken.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 4.2.2.4							
The nursing services shall track sick leave and nursing staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning	1. Evidence that workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments. The results shall be used to create focused actions that improve nursing staff well-being, solve problems, and help retain nursing employees.						

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TOPIC 4.3
POLICIES AND PROCEDURES

STANDARD 4.3.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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, current standard practices and Patients and Family Rights 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;	1. Documented Policies and Procedures, Protocols, Manuals and Guidelines are available to guide nursing care for:						
	a. General care of all patients; and						
	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; and						
	5. The policies and procedures are endorsed and dated.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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 recognition of early deterioration of patient's condition (i.e., Early Warning Score (EWS)) d) policies and procedures on patient nutrition and hygiene. 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.							
CRITERION 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	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; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
practiced in developing relevant policies and procedures where applicable.	3. Documented cross departmental policies and procedures.						
CRITERION 4.3.1.3							
Current policies and procedures are communicated to all staff.	1. Training and briefing on the current policies and procedures/Minutes of meetings; and						
	2. Circulation list and acknowledgement.						
CRITERION 4.3.1.4 (CORE)							
There is evidence of compliance with policies and procedures.	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; and						
	d. Evidence in nursing documentation in line with established policies and procedures.						
CRITERION 4.3.1.5							
Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 4.3.1.6							
The Head of Nursing Services is responsible for the organisation, documentation and implementation of nursing policies and procedures.	1. Policies and procedures for the Nursing Services are endorsed by the Head of Nursing Services.						
CRITERION 4.3.1.7							
The Nursing Services participate in planning, decision making and formulation of policies of the Facility.	1. List of committees where the Head of the Nursing Services is involved; and						
	2. Minutes of Management meetings.						
CRITERION 4.3.1.8 (CORE)							
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.	1. Initial assessment for all inpatient to be completed within 8 hours;						
	2. Nursing reassessment should be done every shift and as when required; and						
	3. Nursing Care Plan documented after each patient's assessment.						
CRITERION 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 individualized patient-focused nursing care plan for each patient to	1. Implementation of Structured 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;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and f) Patient education which shall be documented.	5. Evidence-based nursing services such as Bundle of Care are adopted where applicable and appropriate; and						
	6. Compliance to National Patient Safety Goals related to nursing services.						

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TOPIC 4.4
FACILITIES AND EQUIPMENT

STANDARD 4.4.1
The nursing services shall ensure adequate facilities and equipment that are safe and appropriate, are available, accessible and maintained for the staff to function effectively and to meet the goals and objectives of the nursing services.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 4.4.1.1							
There are adequate and appropriate facilities and equipment with proper utilization of space at each unit to allow staff to carry out nursing services safely and efficiently.	1. Adequate and proper utilization 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						
CRITERION 4.4.1.2 (CORE)							
Nursing Services are provided with sufficient supplies and equipment at all times, including appropriate personal protective equipment.	1. Adequate equipment and supplies for Nursing Services.;						
	2. Equipment are replaced in a planned and systematic manner;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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	3. Stock inventory including personal protective equipment are according to par level;						
	4. Accessibility of critical equipment and consumables at all times. Ensure functionality of critical equipment before use; and						
	5. Equipment has valid Planned Preventive Maintenance (PPM).						
CRITERION 4.4.1.3							
Where specialized equipment is used, there is evidence that only staff who are trained and authorized by the Facility operate such equipment.	1. User training records;						
	2. Competency assessment record; and						
	3. List of staff trained and privileged to operate specialised equipment						
CRITERION 4.4.1.4							
There are sufficient change rooms, rest areas for staff use and storage including safekeeping of their personal items.	1. Provision of adequate staff restroom with staff personal lockers or equivalent to keep staff personal belongings with adequate security; and						
	2. Changing rooms at relevant care areas where appropriate.						
CRITERION 4.4.1.5							
Facilities which provide nursing training shall have specific areas for training and rooms for tutorial.	1. Availability of training/tutorial areas/rooms.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 4.4.1.6 (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care.						

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TOPIC 4.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 4.5.1
The Head Services shall foster high quality performance by involving staff in safety and continuous improvement initiatives, including systematic risk management, active nursing staff involvement and the use of performance data to drive service enhancements. A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of critical services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 4.5.1.1							
There are periodical planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Nursing 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; and f) Re-evaluation for improvement g) Innovation.	1. Planned performance improvement activities include (b) to (f);						
	2. Records, trending and analysis on performance improvement studies and activities;						
	3. Minutes of performance improvement meetings;						
	4. Records of performance improvement and remedial actions adoption into training needs, policy, guidelines and standard operating procedures; and						
	5. Records on innovation, if available.						
CRITERION 4.5.1.2							
The Head of Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement activities to appropriate individuals/personnel within the respective services.	1. Minutes of meetings discussing progress on improvement activities;						
	2. Letter of assignment of responsibilities; and						
	3. Job description.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 4.5.1.3 (CORE)							
The Head of Services shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	1. Documented and approved BCP for emergency services;						
	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes:						
	a. Likelihood;						
	b. Impact; and						
	c. Assigned ownership						
CRITERION 4.5.1.4							
The Head of Services shall ensure that staff are trained and that they complete incident reports. These reports shall be promptly reported, investigated, and discussed by the staff with learning objectives, before being submitted to the PIC of the Facility. Where appropriate, according to the Facility matrix, reported incidents undergo an RCA and corrective and preventive action is taken within the agreed time frame to prevent recurrence.	1. A system for incident reporting is in place and includes the following:						
	a. Training of staff;						
	b. Policy on incident reporting; and						
	c. Register/Records of incidents.						
	2. Completed incident reports:						
	a. RCA;						
	b. Corrective and preventive action plans; and						
	c. Remedial measure.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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	3. Clinical audit including patient safety reviews (e.g., mortality and morbidity review, etc);						
	4. Sentinel Event Investigations with appropriate corrective and preventive actions (CAPA), and oversight by the governing body;						
	5. Grievance Mechanism, both staff and public, including grievance reporting and processing mechanisms are available;						
	6. Minutes of meetings;						
	7. Acknowledgment by Head of Services and PIC; and						
	8. Feedback and learnings from incident reporting are shared with staff.						
CRITERION 4.5.1.5 (CORE)							
There is tracking and trending of specific performance indicators for improvement of the services/patient care sucah as percentage of Intravenous (IV) line complications (needles out, redness skin, infection of sites, extravasation). (Target: ≤0.5%)	1. Specific performance indicators monitored, verified, and validated;						
	2. Records on tracking and trending analysis;						
	3. Remedial measures taken where appropriate;						
	4. Review any performance indicator over a one-year period:						
	a. Have consistently met or exceeded targets; and						

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	b. Continue to show persistent SIQ or performance.						
	5. Where applicable, review the target or identify new indicators.						
CRITERION 4.5.1.6 (NEW)							
The Services participates in the Facility's safety culture assessment. The results are utilized by Service leadership to inform and guide efforts to improve the culture of safety within the Service.	1. Safety Culture Survey for staff						
CRITERION 4.5.1.7							
Feedback on the results of safety and performance improvement activities is regularly communicated to the staff to promote transparency, shared learning, and active engagement in improvement initiatives.	1. Results of safety and performance improvement activities are accessible to staff through education sessions, meetings and digital communications.						
CRITERION 4.5.1.8							
Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.	1. Documentation on performance improvement activities and performance indicators; and						
	2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						

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SERVICE SUMMARY	
OVERALL RATING :	
OVERALL RISK :	

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SERVICE STANDARD 5: PREVENTION AND CONTROL OF INFECTION

PREAMBLE

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 infections among patients, families, healthcare providers, staff of contracted services, students, and visitors.

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.

TOPIC 5.1
ORGANISATION AND MANAGEMENT

Standard 5.1.1
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.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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	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 are measurable in line with the Facility statements available, dated and endorsed;						

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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.	3. Evidence of planned reviews of the above statements (at least once in 3 years or in the event of any major changes);						
	4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc); and						
	5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.						
CRITERION 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.	1. Clearly delineated current organisation chart with line of functions and reporting relationships;						
	2. Organisation chart of the services endorsed, dated and accessible; and						
	3. The organisation chart is revised when there is a major change in any of the items (c)(i) to (iv).						
CRITERION 5.1.1.3							
There is a Hospital Infection and Antibiotic Control Committee (HIACC) chaired by a medical practitioner with knowledge of and special interest	1. Establishment of HIACC;						
	2. Appointment letters of committee members;						

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; and e) Frequency of meetings.	3. Terms of Reference; 4. Minutes of meeting; and 5. Qualification of Chairperson.						
CRITERION 5.1.1.4 CORE							
The Prevention and Control of Infection (PCI) Team and the Antimicrobial Stewardship (AMS) Team shall have a clear governance structure, working relationship, and defined lines of accountability. Both teams report to the Hospital Infection and Antibiotic Control Committee (HIACC). The Prevention and Control of Infection (PCI) Team and	1. Documented Appointment/assignment of: a. Head of PCI Services; b. AMS Coordinator; c. PCI Team members; and d. AMS Team members. 2. Terms of Reference (ToR) for: a. PCI Team; and b. AMS Team.						

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Antimicrobial Stewardship (AMS) Team has a working relationship and reports to the HIACC. The PCI Team shall be headed by an Infectious Disease physician, Clinical Microbiologist or any other specialist/Medical officer trained in IPC and assisted by trained Infection Control Nurses (ICN)/ Personnel (ICP). (To commensurate with the complexity of the services delivered in the facility) The Head of PCI Services and AMS Coordinator are responsible for staff assignment, team leadership, and implementation of relevant infection control and stewardship activities. Their authority, responsibilities, and accountabilities must be clearly documented.	3. Job descriptions for: a. Head of PCI Services; b. AMS Coordinator; and c. Infection Control Nurse (ICN).						
CRITERION 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	1. Appointment letters for link nurses/link personnel; and						
	2. Description of duties and responsibilities for link nurses/link personnel.						
CRITERION 5.1.1.6 (CORE)							
HIACC meetings shall be scheduled and appropriate to the complexity of the services and whenever deemed necessary (such as an outbreak) to discuss issues/matters pertaining to the operations of the PCI services	1. Minutes are accessible, disseminated and acknowledged by the members;						
	2. Attendance list of members with adequate representation of the committee;						

and AMS relevant activities. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff (where appropriate) of the service and implemented.	3. Frequency of meetings as scheduled; and						
	4. Discussion and resolutions are implemented.						
CRITERION 5.1.1.7							
the Head of Prevention and Control of Infection (PCI), is involved in planning, justification and management of budget and resource utilisation of the services.The Chairman of HIACC and / or	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						
CRITERION 5.1.1.8							
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.	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; and						
	h. antimicrobial usage data of broad spectrum antibiotics (eg Carbapenems, Vancomycin.						
CRITERION 5.1.1.9							
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.	1. Minutes of committee meetings, e.g. Health and Safety Committee, Operating Theatre Committee, Equipment Procurement Committee, etc.						
CRITERION 5.1.1.10							
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 immunization; 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;	1. Where appropriate, records are kept on actions taken which include items (a) to (h).						

h) Protocol for post-exposure management for infectious disease and for assignment of infected staff.							
CRITERION 5.1.1.11							
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 sterilization 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	1. There is evidence of items (a) to (h) being implemented.						
CRITERION 5.1.1.12 NEW							
The Head of Services shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	1. Documented and approved BCP for emergency services unanticipated situations;						
	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment.						
	3. Clear actions and staff responsibilities during disruption;						

	4. Record of drills or tests, with follow-up actions, if conducted; and						
	5. Review of Risk Register.						

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TOPIC 5.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

Standard 5.2.1
The PCI Services shall be staffed by adequate numbers of appropriately qualified, trained and privileged staff to achieve the goals and objectives of the service. These designated staff shall maintain competency through Continuing Professional Development (CPD).

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Records on credentials of Head of Service/Team and staff required to fill up the posts within the service (to commensurate with the complexity of the Facility and services);						
	2. Appointment Letters;						
	3. Certification; and						
	4. Training and competency records including privileging (for PCI & AMS)						
CRITERION 5.2.1.2							
The authority, responsibilities and accountabilities of the Head of PCI services and AMS relevant activities are clearly delineated and documented.	1. Appointment/assignment letter for Head of Service; and						
	2. Description of duties and responsibilities.						
CRITERION 5.2.1.3 (CORE)							
The infection control nurse (ICN) shall have post basic/advanced	1. PCI - Post basic /advanced diploma infection control qualification.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
diploma infection control training and certification. The AMS pharmacist shall have attended the AMS pharmacist training program and be certified.	2. AMS – AMS pharmacist has AMS pharmacist training program						
CRITERION 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	1. Surveillance/audit reports and records						
	2. Environmental inspection records						
	3. On-site training records conducted by - ICN in-charge - AMS trained pharmacist						
CRITERION 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	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; and						
	5. Full time staff (Infection Control Nurse) in accordance with national norm commensurate with bed occupancy rate.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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; and						
	4. The job description is acknowledged by the staff and signed by the Head of Service/Team and dated.						
CRITERION 5.2.1.7							
There is evidence of training needs assessment and staff development plan which provide the knowledge and skills required for staff to maintain competency	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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
in their current positions and future advancement.	3. Training schedule/calendar is in place; 4. Training module.						
CRITERION 5.2.1.8							
There are continuing education activities for staff to pursue professional interests and to prepare for current and future changes in practice.	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.						
CRITERION 5.2.1.9							
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.	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.						
CRITERION 5.2.1.10 (CORE)							
The PCI services and AMS relevant activities are involved in	1. Facility-wide orientation programme - PCI - AMS						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.	2. Link nurses/link personnel orientation programme						
	3. Pharmacist orientation programme						
	4. Outsourced services' staff orientation programme - PCI						
	5. Patient and family members orientation checklist - PCI						

Standard 5.2.2 (NEW)
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.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 5.2.2.1							
There is a structured orientation programme for all newly appointed, contracted and outsourced staff to the PCI Services including medical practitioners and for those new to specific areas that include but not limited to the following: <u>General</u> a) Vision and mission of the Facility; b) Organisation chart and reporting structure of the Facility; c) Environment and facility safety policies and	1. Policy requiring all new staff to attend a structured orientation programme;						
	2. There is a Paediatric Services orientation programme with relevant topics not limited to topics covered from (a) to (q); and						
	3. Attendance list.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
procedures including sustainability practices; d) Infection control policies and procedures; e) Policies for performance management, patient safety (IPSG/MPSG) and risk management; f) Ethical practices and code of conduct including medicolegal awareness; g) Management of aggression, violence and harassment; and h) Patient and family rights <u>Services</u> i) Goals, objectives and organisational structure of PCI service; j) Policies and procedures relevant to PCI service; k) Working instructions for patient care; and l) Service continuity plan for PCI service in response to internal and external disasters. <u>Job-specific</u> m) Explanation of particular duties and functions; n) Explanation of the methods of assigning clinical care and the standards of clinical practice; o) Handover communication; and							

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p) Training in basic/advanced life support techniques. q) Technology and equipment use including artificial intelligence, digital care and robotics.							

Standard 5.2.3 (NEW)
The PCI services shall be responsible for promoting and supporting the physical, mental and spiritual well-being of the staff, ensuring a safe and healthy work environment.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 5.2.3.1 (CORE)							
The PCI services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being. a) A health-promoting environment, e.g., stress management, burnout, staff engagement opportunities, workload monitoring, management of work-life balance, healthy, lifestyle programmes e.g. Workplace Wellness Programs, Community-Based Health Initiatives; b) Staff shall be provided with appropriate supervision, support, and advice e.g., mentor mentee program; and	1. The promotion of staff well-being may involve the following:						
	a. Evidence of a health promoting environment eg workplace wellness programme;						
	b. Evidence of proper supervision of staff; and						
	c. Evidence of staff appraisal programme with feedback on underperformance.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
c) There shall be clear procedures for the effective management of underperformance e.g., feedback on performance review or performance appraisal report.							
CRITERION 5.2.3.2 (CORE)							
The PCI services shall establish a safe mechanism for staff to express grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety.	1. PCI staff suggestions and grievance reporting and processing mechanisms are available						
	2. The resolution of workplace issues may involve the following:						
	a. Measures and evidence of PCI staff protection including whistleblowers against violence, bullying, and harassment e.g., awareness campaigns, anonymous reporting channel, Whistleblower policy; and						
	b. Documented policies and procedures for violence activation and staff protection.						
CRITERION 5.2.3.3 (NEW)							
A system shall be created to gather PCI staff feedback about their workplace experience such as burnout which shall be analysed and used to make improvements that enhance the work environment, staff	1. PCI staff feedback (e.g., minutes of sessions or staff satisfactions survey);						
	a. Evidence of action or improvement taken.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
satisfaction, and organisation culture.							
CRITERION 5.2.3.4 (NEW)							
The PCI services shall track sick leave and PCI staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning	1. Evidence that workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments. The results shall be used to create focused actions that improve PCI staff well-being, solve problems, and help retain PCI employees.						

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TOPIC 5.3
POLICIES AND PROCEDURES

Standard 5.3.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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;					

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	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 customized 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; and						
	f. Any Quality Improvement initiatives planned to improve						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	antimicrobial prescribing in the facility.						
	3. Current Ministry of Health Policies and Procedures on Infection Control are available for reference;						
	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; and						
	6. The policies and procedures are endorsed and dated.						
CRITERION 5.3.1.2							
Policies and procedures are developed by a committee in collaboration with various disciplines involving representatives from medical practitioners, pharmacy, nursing, management, and engineering 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.	1. Minutes of committee meetings on consultation with PCI teams when planning relevant policies (e.g. OT committees, OSH).						
CRITERION 5.3.1.3							
Current guidelines, policies and procedures are communicated to all facility staff.	1. Training and briefing on the current policies and procedures/Minutes of meetings;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	2. Circulation list and acknowledgement.						
CRITERION 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.	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; and						
	7. Data collection on usage of broad spectrum or restricted antimicrobials.						
CRITERION 5.3.1.5							
Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By- Laws and statutory requirements are accessible to staff.	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.						
CRITERION 5.3.1.6							
Current reference manuals, pamphlets, journals, and books as well as information and scientific data concerning	1. Copies of relevant documents for reference and guidance.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
infection control and antimicrobial stewardship shall be available for reference and guidance.							
CRITERION 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.	1. Report/documentation on infection risks environmental inspections (e.g. air, water and surface environment); and						
	2. Corrective and preventive actions taken, e.g. training, improvement of infection control practices and other activities.						
CRITERION 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.	1. Records on input from PCI Unit/Team for (a) and (b) where applicable.						
CRITERION 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	1. Minutes of HIACC meeting;						
	2. Reports on:						
	a. Healthcare associated infection rates;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
stewardship policies. Pertinent findings shall be submitted to the appropriate source for necessary action.	b. Surveillance data on infections and infection potentials;						
	c. Implementation of infection control policies.						
	d. Antimicrobial usage of broad spectrum and restricted antimicrobials; and						
	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.						
CRITERION 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.	1. Documented policies and procedures include (a), (b) and (c); and						
	2. Patient's orientation checklist (briefing on infection control practices).						
CRITERION 5.3.1.11 (NEW)							
Patient and families are included in PCI education using accessible formats and encouraged to be active partners in infection control programs a) Leaflets / Posters / materials tailored to patients	1. Records on implementation of (a), (b) and (c); and						
	2. Validation upon on-site inspection of items (a), (b) and (c).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
b) Records of patient and family education sessions c) Feedback forms from patient and families							

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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.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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; and						
	4. Easy access and clear exit routes.						
CRITERION 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. Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.	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; and						
	3. Records and observation on practices.						
CRITERION 5.4.1.3							
Where single use devices or instruments are to be reused, the	1. Policy on reprocessing of single use devices; and						

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processes for reprocessing are consistent with relevant national guidelines and international standards.	2. Observation on practice upon on-site inspection.						
CRITERION 5.4.1.4							
Adequate personal protective equipment (PPE) shall be provided for healthcare providers, patients and visitors where appropriate.	1. Records on requests and supplies of PPE; and						
	2. Observation on practice upon on-site inspection.						
CRITERION 5.4.1.5							
Isolation facilities for patient requiring transmission-based precaution of airborne infection and immunocompromised patients shall comply with regulatory requirements.	1. Isolation rooms available with negative or positive pressure gauge monitoring and airlock with PPE facilities; and						
	2. Record of maintenance shall be kept.						
CRITERION 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.	1. Availability and appropriate hand washing facilities in all patient, staff and visitor areas; and						
	2. Availability of alcohol-based hand rubs in all patient, staff and visitor areas.						
CRITERION 5.4.1.7							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care.						

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TOPIC 5.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

Standard 5.5.1
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.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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 f) Innovation	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; and						
	5. Records on innovation if available						
CRITERION 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	1. Minutes of meetings;						
	2. Letter of assignment of responsibilities; and						

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activities to appropriate individual/ personnel/ committee	3. Terms of Reference/Job description.						
CRITERION 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.	1. System for outbreak management and reporting is in place, which include:						
	a. Protocol on outbreak management;						
	b. Methodology of outbreak management; and						
	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; and						
	7. Feedback given to staff regarding outbreak.						
CRITERION 5.5.1.4							
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;	1. Specific performance indicators monitored: a. PCI; and b. AMS.						
	2. Records on tracking and trending analysis: a. PCI; and b. AMS.						

b) Rate of healthcare associated infections; and 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; and c) Percentage of empirical prescriptions that are reviewed by 72 hours.	3. Remedial measures taken where appropriate: a. PCI; and b. AMS						
	4. Monitoring of PCI indicators:						
	a. Staff trained in Prevention and Control of Infection practices:						
	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; and						
	iii. 85% of existing staff including medical practitioners trained on infection control.						
	b. Rate of healthcare associated infections:						
	i. Healthcare associated infection rate based on current national targets (Target: ≤ 5%)						
	iii. Clinical based surveillance:						
	A. Surgical Site Infection of selected						

	operation based on current local / national / international targets (e.g. clean operation less than 2%);						
	B. Catheter Associated Urinary Tract Infection (CAUTI);						
	C. Ventilator-associated Pneumonia (VAP) based on current local / national / international targets (Target: <10 per 1000 ventilator days)						
	D. 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 Staphylococcus aureus (MRSA)– based on current						

		national targets (Target: ≤ 0.3%					
	ii.	Extended spectrum beta-lactamase (ESBL) producers E.coli (Target: ≤ 0.2%)					
	iii.	Extended spectrum beta-lactamase (ESBL) producers – Klebsiella pneumonia (target: ≤0.3%)					
	iv.	Carbapenem-resistant Enterobacteriaceae (CRE) (target: ≤0.1%)					
	v.	Acinetobacter spp (Target: ≤ 0.3%)					
	vi.	vancomycin-resistant enterococci (VRE) (Target: ≤ 0.1%)					
	vii.	HA-Methicillin Resistant Staphylococcus aureus Bacteraemia (MRSAB) (target ≤ 5 per 10,000 admissions)					
	viii.	HA-Carbapenem Resistant Enterobacteriaceae (CRE) bacteraemia (target ≤ 5 per 10,000 admissions); and					

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	ix. HA- Acinetobacter baumannii bacteraemia (target ≤ 8 per 10,000 admissions).						
	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; and						
	c. Percentage of antimicrobials started empirically that have a documented review at 72 hours based on updated clinical status and new investigation findings.						
CRITERION 5.5.1.5							
Isolation facilities for patient requiring transmission-based precaution of airborne infection and immunocompromised patients shall comply with regulatory requirements.	1. Isolation rooms available with negative or positive pressure gauge monitoring and airlock with PPE facilities.						
	2. Record of maintenance shall be kept						

CRITERION 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.	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.						
CRITERION 5.4.1.7							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care.						

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SERVICE SUMMARY	
OVERALL RATING :	-
OVERALL RISK :	-

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SERVICE STANDARD 06 : PATIENT AND FAMILY RIGHTS

PREAMBLE

Every patient is a unique person; with his/her own needs, values, beliefs and religion. Healthcare facilities ("Facility") 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 needs, values, cultural and psychosocial beliefs and religion.

The facility's approach to Patient and Family Rights is grounded in principles of Equity, Diversity, and Inclusion (EDI), actively working to identify and eliminate disparities in care experiences. Outcomes of patient care are safer and much improved when patients and their families or others who make decisions, participate in care decisions and processes in a way that meets their needs, values, and goals or preferences through a shared decision-making process. Shared decision-making is a process in which the clinicians offer the treatment options, the risks, and benefits, and provide their recommendations; the patients express their values and goals or preferences. Both parties discuss and agree on a decision. Shared decision-making builds trust, allows self-determination and the right to information.

The standards focus on how Patient and Family Rights processes are carried out in the Facility to provide good medical care in an equitable manner considering the delivery system and cost of treatment. The standards also address the interests and rights of patients and families in research and organ and tissue donation and transplantation.

TOPIC 6.1
ORGANISATION AND MANAGEMENT

STANDARD 6.1.1

The Facility is responsible for providing processes that support patient and family rights from the point of accessing care.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 6.1.1.1 (CORE)							
The Facility's management, medical practitioners and providers work collaboratively to protect and promote Patient and Family Rights. There is a documented Policy on Patient and Family Rights as identified in	1. There is documented Patient and Family Rights that address items (a) to (p); and						
	2. Information on the policy is provided to the patient e.g hospital website, information counter, help desk, admission counter etc						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
relevant laws and regulations or guidelines that includes but not limited to the following areas to ensure patients have access to: a) Information on all services provided by the Facility; b) Safe, timely and medically indicated treatment including emergency care, pain management, health promotion and preventive measures, psychological and spiritual support, and rehabilitation and palliative care regardless of age, gender, ethnicity, religion, culture, nationality or citizenship status, social class, and the economic status; c) Medical treatment based on medical indication and not patients' ability to pay; d) Care that is compassionate, respectful, and provided with dignity without discrimination of any kind; e) Reasonable information provided to the patient and next of kin, in a language they can understand, regarding the medical diagnosis, condition, and prognosis; proposed treatments and procedures, and available alternatives; the likelihood of success; potential benefits, risks, and							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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possible side effects or complications, including death or disability with or without treatment; the recovery process and anticipated duration; after-discharge care and continuity of care; as well as the right to refuse treatment or examination at any time and to seek a second opinion; f) Information of the professional position and medical qualifications of the medical practitioner or provider; g) Access to an interpreter if language barrier exists; h) Informed decision-making regarding medical care through a shared decision-making process with the medical practitioner, aligned with the patient's values, goals, and preferences. As autonomous and informed individuals, patients have the right to consent to, refuse, or defer decisions either personally or through a designated representative on proposed treatments, experimental care, participation in research projects, or continued stay in the facility;							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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i) Information on the approximate cost of treatment prior to the provision of care when required; j) Information regarding available financial aid and any other assistance; k) Information to ensure that patients and their families are made aware of their roles and responsibilities; l) Assurance that patients who decline to participate in, or withdraw from, any research shall continue to receive the usual standard of care. Informed consent for research participation must be obtained voluntarily and free from any undue influence or pressure arising from the patient's relationship with the medical professional; m) Information on quality and performance improvement in the Facility; n) Information on organ procurement, donation, and transplantation processes; o) Appropriate mechanisms for resolving disagreements or conflicts regarding treatment plans. In such circumstances, the medical team should conduct multidisciplinary team							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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discussions and family conferences to facilitate open dialogue or consider other conflict resolution mechanisms involving experienced clinicians or administrators. Ethics referral should be made when value conflicts or ethical dilemmas arise; p) Appropriate grievance redressal mechanisms and shall be made aware the availability of such a mechanism for the failure of the medical practitioner to exercise the duty and standard of care required of him/her while treating the patient.							
CRITERION 6.1.1.2							
The Person In Charge (PIC) ensures implementation of Patient and Family Rights in the Facility.	1. Job description of PIC related to Patient and Family Rights; and 2. Minutes of Meetings.						
CRITERION 6.1.1.3 (CORE)							
Policies and procedures guide the implementation of Patient and Family Rights in the Facility.	1. On-site observation on compliance with policies and procedures.						
CRITERION 6.1.1.4							
Medical practitioners and providers trained on the policies and procedures related to Patient and Family Rights and can	1. Records on training programme on Patient and Family Rights e.g. Patient's Charter by FOMCA, Good Medical Practice, and other						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
explain their responsibilities in protecting the patient's needs, values, and goals or preferences.	communication skills or ethical practices training.						
CRITERION 6.1.1.5							
The Head of Services shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	1. Documented and approved BCP for unanticipated situations.						
	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes – a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment.						
	3. Clear actions and staff responsibilities during disruption;						
	4. Record of drills or tests, with follow-up actions, if conducted; and						
	5. Review of Risk Register.						

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, beliefs, and religion.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 6.1.2.1 (CORE)							
There is a process designed to identify and respect patient's personal values, beliefs, and	1. Patient's values, beliefs, and religion are identified or addressed and documented in the patient's notes; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
religion and where applicable those of the patient's family.	2. Information on the policy is provided to the patient e.g hospital website, information counter, help desk, admission counter etc.						
CRITERION 6.1.2.2							
Staff provide care that is respectful of the patient's personal values, beliefs, and religion.	1. Provision of choice of menu when necessary;						
	2. Information on religious support services, e.g. contact number or persons, where appropriate; and						
	3. Evidence of acknowledgement of patient's special request e.g diet, prayers, rituals, visitors.						

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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 6.1.3.1							
There is a process designed for medical practitioners and providers staff to ensure patient's needs for privacy during care and treatment.	1. Policy on patient privacy during care and treatment; and						
	2. On-site observation on with above policy.						
CRITERION 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.	1. On-site observation on compliance to ensuring patient privacy.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 6.1.3.3							
There is a policy and process for patients who may not wish to be photographed, recorded or participate in interviews. Medical practitioners and providers need to enquire about their privacy needs related to care.	1. Policy on consent for patient to be photographed, recorded or participate in interviews.						

STANDARD 6.1.4

The Facility takes measures to protect patients' 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. This process considers the possessions of emergency patients, day surgery patients, inpatients, and those patients unable to make alternative safekeeping arrangements and those incapable of making decisions regarding their possessions, including those brought in dead.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 6.1.4.1 (CORE)							
The Facility has a policy that indicates the extent of its responsibility for patient's belongings or possessions when the patient is unable to assume responsibility and a system to ensure this policy is complied with.	1. Policy on patients' possessions and records; and						
	2. On-site observation on compliance with the above policy.e.g orientation checklist, patient/relatives acknowledgement, record of patient belongings or possessions.						

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STANDARD 6.1.5

The Facility is responsible for protecting patients from physical injury harm by outsiders, other patients, staff, or patients who are at risk of accidentally injuring themselves. Their responsibility is particularly relevant to infants and children, the elderly, and disabled individuals, and others who are vulnerable or at risk.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 6.1.5.1							
The Facility has a policy on risk identification and implementation of safety measures to protect patients from physical harm.	1. Policy on risk identification and implementation of safety measures; and						
	1. Risk identification and implementation of safety measures may include e.g. security guards, closed-circuit television (CCTV), fall prevention strategies, security measures during visiting hours and after visiting hours, passes for visitors, accompanying relatives etc.						
CRITERION 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.	1. Policy on accompanying relatives when indicated;						
	2. Evidence of compliance to the policy on risk identification and implementation of safety measures;						
	3. Standard operating procedures on handling of high-risk patients; and						
	4. Register of visitors after visiting hours for high-risk wards/areas.						
CRITERION 6.1.5.3							
Individuals without identification are identified and managed.	1. Policy on management of individual without identification; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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	2. Facilities for monitoring of suspected intruders, e.g. security/static guard, CCTV, etc.						
CRITERION 6.1.5.4							
Remote and isolated areas of the Facility are monitored.	1. Availability of monitoring facilities in remote and isolated areas; and						
	2. Records on monitoring/surveillance reports.						

STANDARD 6.1.6

Infants and children, the elderly, and disabled individuals, the elderly and others who are vulnerable or at risk receive appropriate protection during an evacuation. Comatose patients and individuals with mental or emotional disabilities are included. Such protection extends beyond physical harms to protection from abuse, negligent care, withholding of services or assistance in the event of an evacuation.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 6.1.6.1							
Infants and children, the elderly, and disabled individuals, others who are vulnerable or at risk 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.	1. Policy on protection for infants and children, the elderly, and disabled individuals, and others who are vulnerable or at risk during an evacuation; and						
	2. Standard operating procedures for evacuation of the above group during emergencies.						
CRITERION 6.1.6.2							
Special attention and priority care are given to children, disabled individuals, the elderly, individuals with mental and	1. Policy on provision of priority care for children, disabled individuals, the elderly, individuals with mental and emotional disabilities and other vulnerable groups;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and						
	4. On-site observation on compliance to policy for priority care. E.g fast track registration counter.						
CRITERION 6.1.6.3							
Staff including medical practitioners understand and implement their responsibilities in the protection processes of patients.	1. Records of orientation/training for in-house staff on the policy; and						
	2. On-site observation on practices.						

STANDARD 6.1.7

Patient health information and medical records are kept private and confidential. Policies and procedures are needed for the safeguarding and protection of confidential information and the conditions to release or share them as required by laws and regulations.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 6.1.7.1							
Patients are informed about laws and regulations that require the release of patient information.	1. Policy on release of patient information; and						
	2. Patient orientation checklist.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 6.1.7.2							
Patients are required to grant permission for the release of information not covered by laws and regulations.	1. Signed consent form on release of patient information.						
CRITERION 6.1.7.3							
There is a policy to identify those eligible to receive patient information.	1. Policy on release of patient information; and						
	2. Consent form/ authorisation letter.						
CRITERION 6.1.7.4 (CORE)							
The Facility ensures patient health information and medical records as confidential.	1. Policy on safeguarding of patient information which includes:						
	a. Policy on release of patient's medical record; and						
	b. Code of conduct of medical records staff						

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STANDARD 6.1.8

The Facility supports patients' and families' rights to participate in the care process. Patients and families participate in the shared decision-making process by making decisions about care, asking questions about care, and even refusing diagnostic procedures and treatment.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 6.1.8.1							
Policies and procedures are developed to support and promote patient and family in shared decision-making processes including making decisions based on information on medical condition, confirmed diagnosis, planned care and treatment.	1. Policy on patient participation in their care and treatment.						
CRITERION 6.1.8.2 (CORE)							
Patients and the family are informed about the outcomes of care and treatment, including where appropriate the unanticipated outcomes.	1. Interview of patient;						
	2. Documentation in the medical records; and						
	3. Consent form where applicable.						
CRITERION 6.1.8.3							
Patients are informed about their rights and responsibilities related to refusing or discontinuing treatment and seeking a second opinion. Patient's refusal shall be acknowledged, respected and patient well-being is assured.	1. Interview of patient;						
	2. Orientation checklist; and						
	3. Documentation in the medical records of the patient's decision, e.g. At Own Risk (AOR) discharge form, refusal form, etc.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 6.1.8.4 (CORE)							
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.	1. Staff orientation/training records; and						
	2. Minutes of Meeting.						

STANDARD 6.1.9

The Facility respects the patient's and family's needs, values, and goals or preferences to care and services within ethical standards through the guidance and support of a clinical ethics committee.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 6.1.9.1 (CORE)							
The Facility has a clinical ethics committee that aims to improve the quality of care by identifying, analyzing, and resolving ethical dilemmas in clinical care and practice, empowers ethical practices, and guides and supports stakeholders by respecting their needs, values and goals, and providing ethical clarity and acceptable options. a) Cases with ethical dilemma can be discussed by the committee using a structured approach through ethical questioning, information gathering, ethical analysis, and recommendation.	1. Records of cases discussed in a clinical ethics committee;						
	2. Policies or guidelines developed by the clinical ethics committee. Covers i-xi;						
	3. Minutes of meeting that include the development of the policies and guidelines, discussion of cases, or reports of educational activities;						
	4. Training and Implementation of policies and guidelines e.g. training or patient's records;						
	5. Reports of ethics educational activities e.g. CME, grand rounds, courses or workshops;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
a) Policies or guidelines below can be developed or discussed by a clinical ethics committee: i) End-of-life care and conversation ii) Deciding for critically ill patients and goals of care discussion, which includes withholding life-sustaining treatment or resuscitative treatment iii) Management of discharge against medical advice iv) Disclosure and apology during a medical error v) Management of social determinants of health vi) Management of non-citizens barriers to healthcare vii) Resource allocation and crisis standards of care viii) Professionalism and ethical practices ix) Consent and decisional capacity x) Surrogate decision-making and guardianship for patient without family members xi) Guidance on responding to patient or family discrimination against healthcare workers.	6. Agenda on Ethics in one of the Facility's committee meetings (non-specialist facility); 7. Documentation in medical records regarding decision made on withholding resuscitative service; and 8. Policy on Do Not Resuscitate.					

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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b) Ethics educational activities can include CME, ethics grand rounds, courses, or workshops.							

STANDARD 6.1.10
The Facility supports the patient's rights to appropriate assessment and management of symptoms that could have adverse physical and psychological effects.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 6.1.10.1							
The Facility supports the patient rights to appropriate assessment and management of symptoms.	1. Assessment and care plan records.						
CRITERION 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.	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; and						
	3. Adherence to the treatment/ care plan e.g. patient's note, nursing note, lab results, etc.						

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STANDARD 6.1.11

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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 6.1.11.1							
The Facility recognizes and manages the needs of dying patients.	1. Policy on end of life care.						
CRITERION 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.	1. Staff orientation; and						
	2. Availability of contact number/person of respective religious beliefs/support centres.						

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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Policy on grievance mechanism;						
	2. Patient orientation checklist;						
	3. Patient Charter; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	4. Brochure on Patient and Family Rights.						
CRITERION 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.	1. Appointment letter of patient relations officer;						
	2. Job description;						
	3. Facility directory – contact person to address complaint;						
	4. Patient orientation checklist; and						
	5. Records of complaints.						
CRITERION 6.1.12.3							
There is documented procedure to address all grievances which include: 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.	1. Flow chart on grievances mechanism;						
	2. Acknowledgement to the complainant upon receipt of complaint; and						
	3. Results of the investigations are communicated to the complainant within ten (10) working days.						
CRITERION 6.1.12.4							
There are documented policies and procedures to identify how the patients and families	1. Policies and procedures on participation of patients and families in the grievance process.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
participate in the grievance process.							

STANDARD 6.1.13
CONTINUITY OF CARE

Continuity of care is fundamental to ensuring safe, effective, and person-centred healthcare services. The organisation establishes and implements systems that promote coordinated care throughout the patient journey—beginning at the point of entry, across departments and services, during referrals or transfers, and upon discharge or transition to other levels of care.

The process ensures that information is communicated accurately, timely, and comprehensively among healthcare providers, patients, and families. Special attention is given to vulnerable populations, complex cases, and inter-facility transitions.

The organisation's approach to continuity of care reflects its commitment to patient safety, quality improvement, and collaboration across the healthcare network, supporting seamless, integrated, and holistic care that extends beyond hospital walls.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 6.1.13.1 (CORE)							
The hospital admission process serves as the gateway to patient care and must ensure that all patients are received with dignity, efficiency, safety, and respect for their individual needs. A structured admission process guarantees that patient identification, consent, financial, and clinical information are accurately obtained, verified, and documented to support continuity of care and safe treatment.	1. The hospital has documented and approved policies and procedures for the admission and registration process:						
	a. Inpatient and emergency admissions;						
	b. Outpatient registration; and						
	c. Admission/discharge criteria for specialty units.						
	2. Policies cover patient identification, registration, consent, orientation, financial clearance, and handling of urgent/emergency admissions;						

DISTRIBUTION

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
A systematic and person-centred approach to hospital admission, ensuring that: a) Timely access to care is facilitated without unnecessary delay; b) Accurate patient identification is performed at every point of entry; c) Clinical, administrative, and financial information is clearly documented and communicated; d) Patients and families are oriented to the hospital environment, services, rights, and responsibilities; e) Special needs and risks (such as language barriers, disabilities, or urgent conditions) are identified and appropriately managed; and f) The admission process complies with legal, ethical, and regulatory requirements in Malaysia.	3. Policies are consistent with legal, ethical, and regulatory requirements in Malaysia;						
	4. System in place to manage and re-assess bed allocation to maintain an effective patient flow through available bed capacity and create bed capacity;						
	5. Staff are trained and competent in applying admission policies and procedures; and						
	6. Cancelled admissions by either the healthcare facility or the patient are monitored and analysed with results used for improvement.						
CRITERION 6.1.13.2 (CORE)							
The hospital shall establish and implement a structured, timely, and comprehensive process for the assessment of patients to ensure safe, effective, and person-centred care. The	1. The hospital has a documented policy and procedure for patient assessment, including initial and ongoing assessments;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
assessment process shall begin at the point of entry and continue throughout the continuum of care, including outpatient, inpatient, emergency, surgical, and specialized services. The purpose of the assessment is to determine the patient's health needs, risks, and treatment priorities, thereby enabling the development of an individualized plan of care. Assessments shall be performed by qualified healthcare professionals using evidence-based tools and methods that are appropriate to the patient's condition, age, culture, language, and level of understanding. Reassessments shall be conducted at intervals based on the patient's clinical status and care setting, and when significant changes occur in the patient's condition. The hospital shall ensure that assessment findings are documented, communicated, and integrated into the multidisciplinary plan of care. The assessment process shall also address special needs, such as nutritional, functional, psychosocial, cultural, spiritual, palliative, and rehabilitative requirements. In addition, risks	2. Initial assessment of patients is conducted at the point of entry (inpatient, outpatient, emergency) within defined timeframes;						
	3. Assessments are performed by qualified and credentialed healthcare professionals;						
	4. The assessment process includes a review of medical, nursing, psychological, social, and functional needs of the patient;						
	5. Risks such as falls, pressure injuries, pain, infection, suicide, and abuse/neglect are systematically assessed and documented;						
	6. Nutritional status, cultural, spiritual, and language needs are identified and documented where relevant;						
	7. The hospital uses standardized, evidence-based tools or criteria for patient assessment (e.g., pain scales, fall risk tools);						

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such as falls, pressure injuries, pain, infection, and abuse/neglect shall be systematically evaluated.	8. Staff are trained and competent in conducting patient assessments according to hospital policy;						
	9. There is evidence of monitoring and evaluation of compliance with patient assessment processes.						
CRITERION 6.1.13.3 (CORE)							
The hospital ensures that the transition of patient care across departments, services, and external healthcare facilities is safe, coordinated, and person-centred. Transitions of care—including referral, transfer, handover, and discharge—are guided by structured processes that emphasize continuity, timeliness, and accuracy of information. The hospital facilitates effective communication between care providers, patients, and families to minimize risks, prevent information gaps, and support continuity of treatment plans. Transitions are documented, standardized, and aligned with patient needs, legal requirements, and national healthcare policies.	1. The hospital has a documented policy and procedure for transition of care (referral, transfer, handover, discharge, and external referral);						
	2. Standardized handover tools (e.g., SBAR, checklist, electronic record) are used for internal and external transitions;						
	3. Patient identity is verified and confirmed during all transitions of care;						
	4. Patient care information (diagnosis, treatment, investigations, medications, pending results, care plan) is communicated accurately and timely during transitions;						
	5. There is a policy for the referral of patients from one healthcare professional to another;						
	6. There is a written policy for referral and/or discharge of patients;						

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The goal is to ensure that every patient receives seamless care throughout their journey in the healthcare system, with special attention to vulnerable populations, complex cases, and high-risk transfers.	7. A standardized pre-discharge checklist (see guidance) is used to assess that the actions required to discharge the patient have been completed; and						
	8. A discharge summary is prepared at discharge by a qualified individual.						
CRITERION 6.1.13.4 (CORE)							
Early recognition and prompt management of clinical deterioration are critical to ensuring patient safety and quality of care. The hospital establishes and implements structured processes to detect, escalate, and respond to signs of deterioration in a timely, coordinated, and standardized manner. These processes ensure that: a) Patients at risk of deterioration are identified through systematic monitoring, validated screening tools, and clinical judgment. b) Clinical staff are trained and competent in recognizing	1. The hospital has a documented policy and procedure for the recognition, escalation, and management of clinical deterioration;						
	2. Vital signs and physiological parameters are monitored at defined intervals appropriate to patient condition, and early warning/track-and-trigger systems are used where applicable;						
	3. An escalation protocol/response pathway (e.g., Rapid Response Team, Code Blue, or graded response) is clearly defined, communicated, and accessible to staff;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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early warning signs and initiating appropriate escalation protocols. c) Clear communication channels and escalation pathways are in place, enabling timely involvement of senior clinicians or rapid response teams. d) Documentation of deterioration events, escalation actions, and interventions is complete, accurate, and retrievable for audit and learning purposes. e) The hospital regularly reviews adverse events, unplanned ICU admissions, cardiac arrests, and mortality related to failure-to-rescue, using these findings for continuous quality improvement. This standard ensures that hospitals adopt a proactive approach to patient safety, minimizing preventable harm and improving outcomes through early intervention and coordinated care.	4. Data on deterioration events (unplanned ICU admissions, Code Blue activations, cardiac arrests, mortality, failure-to-rescue) are collected and analysed; and						
	5. Clinical staff are trained and competent in recognizing signs of deterioration and initiating escalation protocols (orientation, CME, drills, simulation).						

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STANDARD 6.1.14
PATIENT AND FAMILY EDUCATION
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.

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CRITERION 6.1.14.1							
a) Patient's and family's barriers to learning are assessed and documented; and b) Education by facility staff is provided to patients and families in a manner that accommodates their identified needs.	1. Education provided to patients and families is documented in the patient medical record;						
	2. Educational pamphlets are developed and is accessible to all; and						
	3. There is a process to verify that patients and families receive and understand the education provided.						

TOPIC 6.2
INFORMED CONSENT
The informed consent process is clearly defined and documented in policies and procedures. Relevant laws and regulations are incorporated into the policies and procedures. The ethical principles that guide informed consent are respect for patient autonomy and respect for persons. Seven elements that are required in any informed consent are: capacity, voluntariness, disclosure, recommendation, understanding, decision, authorization. Ethically, as an autonomous person, the informed patient can consent, refuse, or defer the decision later or to others.

STANDARD 6.2.1
Patient's informed consent is obtained through a process defined by the Facility and carried out by trained medical practitioners.

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CRITERION 6.2.1.1 (CORE)							
There are documented policies and procedures on informed consent that clearly:	1. Standard Operating Procedures (SOP) on obtaining consent;						

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a) Define decisional capacity required for an informed consent: i) Capacity could be assessed by the medical practitioners at bedside following appropriate approaches and questions, specific and time-dependent for the particular treatment decision; ii) Decisional capacity involves the ability to communicate a choice, understand the relevant information, reason about treatment options, and appreciate the consequences; iii) Principles of evaluating capacity: it has to be assumed, with practical steps taken to assess the language used so that the patient can understand the information provided, free from medical jargons and abbreviations, and not being judged for lacking the capacity from an unwise decision; and iv) A lack of capacity could be permanent or temporary.	2. Evidence of signed consent forms by patient or family member and medical practitioner responsible for the procedures/treatment and other relevant documentations;						
	3. Interview of patient as observed on-site; and						
	4. Documentation in medical records (e.g. explanation of risks and complications to the patient or family members.)						

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b) Define the disclosure of information in an informed consent process with explanation of the following elements: i) Patient's diagnosis, condition, and prognosis; ii) Proposed treatment (s) or procedure(s) and available alternatives; iii) Likelihood of success ; iv) Potential benefits, and risks and possible side-effects and complications, including death and disability, related to treatment or procedures or no treatment; v) Recovery process and anticipated duration and procedures; vi) After discharge care and continuity of care; vii) Right to refuse treatment or examination at any time and to second opinion; viii) Name of the person providing the treatment/procedure; and ix) Discussion of reasonable alternatives, including the option of no active treatment (with an explanation of							

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palliative or supportive care options). c) Outline the procedures and conditions of which a written consent, especially for invasive or surgical procedures, is obtained from: i) The patient first and foremost; ii) The spouse, parent or next of kin if the patient is incapacitated or lack the capacity; or iii) The parent or guardian where the patient is below eighteen (18) years of age; and iv) In a language that is understood by patient and family/caregivers, free from medical jargons or abbreviations. Through a shared decision-making process with the medical practitioner that is aligned with the patient's values, goals, and preferences.							
CRITERION 6.2.1.2							
Consent is not required during a medical emergency or 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	1. Policy on obtaining consent for life-threatening cases that need immediate intervention.						

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that the delay would endanger the life of the patient.							
CRITERION 6.2.1.3 (CORE)							
Informed consent is obtained before surgery, anesthesia, the 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.	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); and						
	3. Validity of the signed consent form is 30 days.						
CRITERION 6.2.1.4							
There is a list in the Facility of all types of treatments and procedures that require informed consent.	1. Approved list of all types of treatments and procedures that require informed consent.						

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TOPIC 6.3
RESEARCH
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:
a) expected benefits;
b) potential risks and complications;
c) procedures that shall be followed.
All human research proposals that involve multicenter trials shall be registered with the National Medical Research Registry (NMRR) and approved by the respective research ethics committees (RECs).

STANDARD 6.3.1
A Facility that conducts research, investigations, or clinical trials involving human subjects has a responsibility to the patient's health and well- being.

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CRITERION 6.3.1.1							
There is a committee with documented Standard Operating Procedure & Terms of Reference to oversee all research conducted in the Facility involving human subjects.	1. Establishment of Research Committee;						
	2. Standard Operating Procedure & Term of Reference; and						
	3. Minutes of meetings regarding the development or revision of SOP & TOR.						
CRITERION 6.3.1.2							
To ensure the ethical processes required in the planning and conducting of a research: a) All human research must be registered with the National Medical Research Registry (NMRR); b) Clinicians or researchers who conduct human research in the facility must have Good Clinical Practice (GCP) certification; and	1. SOP that includes NMRR registration, GCP certification, and the approval by REC.						

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c) Research is approved by the respective research ethics committee (REC) before the start of the research.							
CRITERION 6.3.1.3							
a) The Facility informs patients and families in advance about: i) Potential research activities; and ii) Informed consent and safety monitoring processes. b) The clinicians or researchers inform patients and families in the Patient Information Sheet (PIS) during informed consent process about: i) Research objectives and procedures; ii) Research participants responsibilities; iii) Potential benefits and risks; iv) Voluntary participation by patients without undue influence or pressure which may arise from a dependent doctor-patient relationship; v) Provision of standard of care irrespective of research participation or non-participation; vi) Withdrawal from participation; and	1. Documentation of (a) to (e) in the patients' medical records; and						
	2. Samples of patients' participation forms.						

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vii) Suspension or termination of the research.							
CRITERION 6.3.1.4							
Outcomes of patients who choose to participate in clinical research, investigations, or clinical trials are constantly reviewed to protect their well-being and health.	1. Periodical report of clinical research related to outcomes of trials; and						
	2. Medical records of participating patients.						
CRITERION 6.3.1.5							
Informed consent is obtained before the patient participates in clinical research, investigations, or clinical trials.	1. Samples of consent forms from participating patients. The informed consent should be taken before the patients participate in the clinical trials.						

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TOPIC 6.4
ORGAN, TISSUE AND CELL DONATION
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.

STANDARD 6.4.1
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.

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CRITERION 6.4.1.1							
There is a committee with documented Terms of Reference to oversee all the procurement, donation process, and transplantation of organs/tissue/cells in the Facility.	1. Establishment of Hospital Transplantation Technical Committee;						
	2. Term of Reference; and						
	3. Minutes of Meetings.						
CRITERION 6.4.1.2 (CORE)							
There are policies, procedures and relevant information available to guide the procurement, donation process, and transplantation of organs/tissue/cells, consistent with relevant laws and regulations, and respecting the individual's values, beliefs, and religion.	1. Policy on organ/tissue/cell procurement, donation process and transplantation process in accordance to National Policy on Organ Transplantation Ministry of Health, Act, Guidelines, Facility policies & procedures, and relevant regulations and guidelines;						
	2. Standard operating procedures for procurement, donation process and the transplantation of organs/tissues/cell in accordance to National Policy on Organ Transplantation Ministry of Health, Act, Guidelines, Facility policies & procedures, and relevant regulations and guidelines; and						

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	3. Availability of educational and promotional material on donation and transplantation of organs.						
CRITERION 6.4.1.3 (CORE)							
Staff are trained in the policies and procedures on organ/tissues/cell donation and transplantation.	1. Availability of trained staff to facilitate the organ, tissue and cell donation and transplantation; and						
	2. Staff training records and certification.						
CRITERION 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.	1. Policy on coordination with relevant agencies responsible for all or a part of the procurement, banking, transportation, and transplantation process; and						
	2. Document on coordination with relevant agencies						
CRITERION 6.4.1.5							
Informed consent shall be obtained from the patient, or next-of-kin prior to the procurement and transplantation of organs, tissues, and cells, with proper documentation and adherence to legal and ethical requirements.	1. Samples of consent forms from donor, patient, or next-of-kin prior to the procurement of organ, tissues, organs, and cells, with proper documentation.						

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TOPIC 6.5
PERSON-CENTRED CARE COORDINATION
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.

STANDARD 6.5.1
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. The facility shall promote coordinate inter-services health care provision to address the patient's co-morbidities in a holistic manner, which includes health promotion, disease prevention, diagnosis, treatment, disease- management, rehabilitation and palliative care services.

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CRITERION 6.5.1.1							
There shall be inter-services coordination of care for patients with co- morbidities.	1. Cross departmental policy on case management.						
CRITERION 6.5.1.2							
The Facility ensures efficient coordination for patients requiring multidisciplinary care, which includes: a) Transparent, accessible, and understandable service protocols of interdisciplinary patient management flow; b) Appropriate scheduling of appointments; c) Reminder notices for specific interventions; d) Protocols for referral and discharge as well as patient's/family's; and e) Involvement.	1. Protocols for referral to multidisciplinary team;						
	2. Records on multidisciplinary discussion/patients' related medical records;						
	3. Records of patients' notices/reminders; and						
	4. There is documentation of patient /family involvement in the discharge / referral process						

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SERVICE SUMMARY	
OVERALL RATING :	-
OVERALL RISK :	-

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SERVICE STANDARD 07: HEALTH INFORMATION MANAGEMENT SYSTEM (HIMS), DIGITAL CARE AND ARTIFICIAL INTELLIGENCE (AI)

PREAMBLE

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 -

a) Identifying information needs;
b) Developing an information management system;
c) Defining, capturing, and managing data and information;
d) Analyzing data and transforming it into actionable information;
e) Transmitting and reporting data and information; and
f) Utilization of information in management decisions.

The principles of good information management apply to all forms of documentation and communication, whether paper-based, electronic, or hybrid. This includes ensuring accuracy, completeness, confidentiality, accessibility, and timely availability of information. Regardless of the medium used, information must be managed in a way that supports continuity of care, complies with legal and ethical standards, and upholds the integrity of clinical and administrative decision-making.

In alignment with the evolving landscape of healthcare, this standard is further expanded to include the domains of Digital Care and Artificial Intelligence (AI). The Health Information Management System (HIMS) may operate within a digitally integrated environment, leveraging intelligent technologies to support data-informed care, advanced analytics and responsive decision-making.

Digital Care requires the provision, facilitation, and enhancement of clinical healthcare services through the use of information and communication technologies (ICT), where the patient and the care provider are not in the same physical location, or where technology is used to fundamentally alter the care interaction. It represents a shift from using technology merely to record care, to using it to deliver and manage care.

It is characterized by direct clinical purpose, patient interaction, and the potential to generate new clinical data. Its implementation requires specific governance for safety, quality, and accessibility that goes beyond the previous HIMS policies. Digital care platforms, including Electronic Medical Records (EMR), telehealth solutions, mobile applications, and connected devices - extend the scope of health information, requiring robust interoperability, real-time access, and adaptive governance. AI tools, increasingly used in clinical decision support, risk prediction, and operational optimization, bring transformative potential but also necessitate ethical and quality oversight.

The bundle components of this standard, HIMS, Digital Care, and AI, may be adopted modularly depending on the facility's level of digital maturity. While some institutions may not yet implement a full Health Information System (HIS), they may still utilize discrete digital care solutions or AI-based tools. As such, each element is structured to allow standalone implementation while collectively supporting an integrated and ethically governed information ecosystem.

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TOPIC 7.1
ORGANISATION AND MANAGEMENT

Standard 7.1.1
The Health Information Management System (HIMS) Services shall be organized and administered to facilitate the collation, aggregation, and analysis of Facility demographic data through an established system, which includes confidentiality*, safekeeping, and retrieval of medical records and documents, both paper-based and electronic, related to patient care.

a) * Personal Data Protection Act 2010 (Act 709) as amended (including the Personal Data Protection (Amendment) Act 2024 and any regulations/guidelines in force).
b) *Guidelines for Handling and Management of Patient Medical Records at Ministry of Health Malaysia Facilities 2023 or latest available version.
c) *General Hospital Operational Policy 2025.
d) Garis Panduan Pengadaptasian Kecerdasan Buatan (AI) Untuk Sektor Awam 2025 oleh Jabatan Digital Negara

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

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CRITERION 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, Digital Care and AI 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.	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body;						
	2. Goals and objectives of the manual HIMS Services, are measurable in line Digital Care and AI with the Facility statements are available, endorsed and dated;						
	3. Goals and objectives of the HIMS Services, Digital Care and AI (or hybrid) are measurable in line with the Facility statements are available, endorsed and dated;						
	4. Evidence of planned reviews of the above statements (at least once in 3 years or in the event of any major changes);						

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	5. These statements are communicated to all staff (orientation programme, minutes of meeting, etc.); and						
	6. Achievement of goals and objectives are monitored, reviewed and revised accordingly.						
CRITERION 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 Change (PIC) or Hospital Director, Head of Services (HOS) and the staff of the HIMS Services, Digital Care and AI; b) Representation of the structure of HIMS Services, Digital Care and AI shall include Clinical Champion, IT Champion, Data Governance (Medical Record Champion) 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; and iv) Staffing patterns.	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC)/ Hospital Director, HOS and staff of the HIMS Services;						
	2. Organisation chart of the service is endorsed, dated and accessible; and						
	3. The organisation chart is revised when there is a major change in any of the items (c)(i) to (iv).						

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CRITERION 7.1.1.3							
Regular staff meetings are held between the HOS 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.	1. Minutes are accessible, disseminated, well communicated, and acknowledged by relevant staff members; 2. Attendance list of members with adequate representation of the service; 3. Frequency of meetings as scheduled; and 4. Discussion and resolutions are implemented.						
CRITERION 7.1.1.4							
a) The HOS is involved in the strategic planning, justification and management of the budget and resource utilization of the services; and b) The Facility shall have a documented strategy for assessment, costing, implementation, and ongoing management of digital care systems, including electronic medical records, teleconsultation platforms, and mobile health technologies.	1. Minutes of Facility-wide management meeting; 2. Documented evidence for: a. HIMS Services, including the request for allocation of budget and resources (staffing, equipment, etc.); and b. Endorsed Digital Health Strategic document which details the plan for assessment, budgeting, implementation, and management of digital care systems.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	3. Approved budget and resources, including financial documents showing allocation for HIMS, digital care technologies, and related infrastructure.						
CRITERION 7.1.1.5							
The Head of HIMS Services is involved in the appointment and/or assignment of staff.	1. Records on staff interview (if applicable);						
	2. Appointment/assignment letter of Head of Service;						
	3. Job description of HOS;						
	4. Records on staff deployment; and						
	5. Duty roster.						

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CRITERION 7.1.1.6							
The HIMS Services plan and design information management processes to meet internal and external information needs.	1. Policies and procedures are available to plan and design information management processes.						
CRITERION 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 International Classification of Diseases (ICD); h) Length of stay in days; i) Autopsies; j) Number of new registrations; and k) Number of follow-up.	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) shall be made available.						

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CRITERION 7.1.1.8							
Appropriate statistics and records shall be maintained in relation to the provision of HIMS Services and used for improving the services and patient care.	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;						
	d. Incident reports;						
	e. Other records to be made available, such as:						
	i. Medical reports;						
	ii. Data from Medical Board;						
	iii. Medicolegal inquiries;						
	iv. Post mortem reports; and						
	v. Data on performance improvement activities, including performance indicators; and						
	vi. Use of digital signature.						
CRITERION 7.1.1.9 (CORE)							
A Medical Records Committee chaired by a medical practitioner shall be responsible to:	1. Appointment letters for Chairman and committee members;						
	2. Terms of Reference (TOR);						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; 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 PIC or Hospital Director 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 HOS, medical and nursing staff representatives, and other healthcare personnel who could contribute substantially to the HIMS Services.	3. Minutes of meeting; 4. Medical Records audit report; and 5. Current and approved Abbreviations List.						
CRITERION 7.1.1.9							
The Head of Services shall ensure a basic Business	1. Documented and approved BCP for unanticipated situations;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment.						
	3. Clear actions and staff responsibilities during disruption;						
	4. Record of drills or tests, with follow-up actions, if conducted; and						
	5. Review of Risk Register.						

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TOPIC 7.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

Standard 7.2.1
The HIMS Services shall be directed by and staffed with suitably qualified and trained personnel to achieve the goals and objectives of the services. Digital Literacy and AI Competency Framework shall be established where applicable.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 7.2.1.1							
The HOS 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.	1. Records on credentials of HOS 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; and						
	4. Training and competency records.						
CRITERION 7.2.1.2							
The authority, responsibilities and accountabilities of the HOS are clearly delineated and documented.	1. Appointment/assignment letter for HOS; and						
	2. Description of duties and responsibilities.						
CRITERION 7.2.1.3							
Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the needs of the services.	1. Number of staff and qualification should commensurate with workload;						
	2. Staffing pattern; and						
	3. Duty roster.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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; and 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; and vi) Statutory Regulations.	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 specialization skills;						
	3. Relevant privileges granted where applicable; and						
	4. The job description is acknowledged by the staff and signed by the Head of Service and dated.						
CRITERION 7.2.1.5							
Personnel records on training, staff development, leave, and other matters are maintained for every staff member, either in hardcopy, softcopy, or both.	1. Staff personal records include:						
	a. Staff biodata;						
	b. Qualification and experience;						
	c. Training record;						
	d. Competency record and privileging;						
	e. Leave record; and						
	f. Confidentiality agreement.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 7.2.1.6 CORE							
There is a structured orientation programme for all newly appointed, contracted and outsourced staff to the Services that include but not limited to the following: <u>General</u> a) Vision and mission of the Facility; b) Organisation chart and reporting structure of the Facility; c) Environment and facility safety policies and procedures including sustainability practices; d) Infection control policies and procedures; e) Policies for performance management, patient safety (IPSG/MPSG) and risk management; f) Ethical practices and code of conduct including medicolegal awareness; g) Management of aggression, violence and harassment; and h) Patient and family rights. <u>Services</u> i) Goals, objectives and organizational structure of Services; j) Policies and procedures relevant to Services;	1. Policy requiring all new staff to attend a structured orientation programme;						
	2. There is Services orientation programme with relevant topics not limited to topics covered from (a) to (q); and						
	3. Attendance list.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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k) Working instructions for patient care; and l) Service continuity plan for Service in response to internal and external disasters. <u>Job-specific</u> m) Explanation of particular duties and functions; n) Explanation of the methods of assigning clinical care and the standards of clinical practice; o) Handover communication; p) Training in basic/advanced life support techniques; and q) Technology and equipment use including artificial intelligence, digital care and robotics.							
CRITERION 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.	1. Performance appraisal for staff is completed upon probationary period and as an annual exercise.						
CRITERION 7.2.1.8							
There is evidence of Training Needs Assessment and staff development plans which provide the knowledge and skills required for staff to maintain competency in their current positions and future advancement.	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; and						
	4. Training modules.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Training records on continuing education activities are kept and maintained for each staff member;						
	2. Contents of training programme; and						
	~~3.~~ Certificate of attendance/degree/post basic training.						
CRITERION 7.2.1.10							
The Facility shall ensure access to technical expertise to support the safe and effective use of digital health systems and provide relevant training for staff involved in their operation or use.	1. Roster or contract of digital health technical support personnel, whether internal or outsourced, with defined roles;						
	2. Training records for the HIMS, clinical staff, and all related staff, including documented sessions on using, troubleshooting, and integrating digital systems;						
	3. Information and communication technology support request logs or help desk records that show staff engagement with technical support for operational issues; and						
	4. Meeting minutes or reports that provide evidence of the periodic review and evaluation of digital health system challenges and staff competency gaps.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 7.2.1.11							
A defined competency framework for staff digital literacy (e.g., EMR proficiency, telehealth etiquette) and, where AI is deployed, specific competencies for AI tool interaction, interpretation, and limitation awareness shall be established and integrated into training plans.	1. Training Development Plan						
	2. Evidence of training for Digital Literacy and AI Competency conducted						

Standard 7.2.2 (NEW)
The HIMS services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the staff, ensuring a safe and healthy work environment.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 7.2.2.1 (CORE)							
The HIMS services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being. a) A health-promoting environment, e.g., stress management, burnout, staff engagement opportunities, workload monitoring, management of work life balance, healthy, lifestyle programmes e.g. Workplace Wellness Programs, Community-Based Health Initiatives;	1. The promotion of staff well-being may involve the following:						
		a. Evidence of a health promoting environment e.g., workplace wellness programme;					
		b. Evidence of proper supervision of staff;					
		c. Evidence of staff appraisal programme with feedback on underperformance.					

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
b) Staff shall be provided with appropriate supervision, support, and advice e.g., mentor mentee program; and c) There shall be clear procedures for the effective management of underperformance e.g., feedback on performance review or performance appraisal report.							
CRITERION 7.2.2.2 (CORE)							
The HIMS services shall establish a safe mechanism for staff to express grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety.	1. Staff suggestions and grievance reporting and processing mechanisms are available; and						
	2. The resolution of workplace issues may involve the following:						
	a. Measures and evidence of staff protection including whistleblowers against violence, bullying, and harassment e.g., awareness campaigns, anonymous reporting channel, Whistleblower policy; and						
	b. Violence, bullying, and harassment e.g., awareness campaigns, anonymous reporting channel, Whistleblower policy.						
CRITERION 7.2.2.3 (NEW)							
A system shall be created to gather staff feedback about their	1. Staff feedback (e.g., minutes of sessions or staff satisfactions survey):						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
workplace experience such as burnout which shall be analysed and used to make improvements that enhance the work environment, staff satisfaction, and organisation culture.	a. Evidence of action or improvement taken.						
CRITERION 7.2.2.4 (NEW)							
The HIMS services shall track sick leave and staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning	1. Evidence that workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments. The results shall be used to create focused actions that improve staff well-being, solve problems, and help retain employees.						

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TOPIC 7.3
POLICIES AND PROCEDURES

Standard 7.3.1
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.

The HIMS, where applicable, shall support and enable health information interoperability within the facility and with external authorized care providers and health information exchanges (HIEs). Policies shall govern the secure, standards-based (e.g., HL7 FHIR, SNOMED CT where possible) exchange of patient summaries, laboratory results, and medication lists to support integrated care pathways.

Cyber Security (Period for Cyber Security Risk Assessment and Audit) Regulations 2024 come into operation on 26 August 2024, which it states to:
a) Conduct a cyber security risk assessment at leadt once a year; and
b) Carrying out an audit at least once in every two years.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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, authorized and dated. There is a mechanism for and evidence of a periodic review at least once in every three (3) years.	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; and						
	4. The policies and procedures are endorsed and dated.						
CRITERION 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	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;						

DISTRIBUTION

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; c) Use of standardized 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; and e) Identification of those authorized to make entries and addendums in the patient's medical record, with date and time of entry. Cross departmental, facility and cross state collaboration is practiced in developing relevant policies and procedures where applicable.	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 shall include but not limited to (a) to (e); and						
	6. Electronic information system security policies.						
CRITERION 7.3.1.3							
Current policies and procedures are communicated to all staff.	1. Training and briefing on the current policies and procedures/Minutes of meetings; and						
	2. Circulation list and acknowledgement.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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CRITERION 7.3.1.4 (CORE)							
There is evidence of compliance with policies and procedures, including Patients and Family Rights.	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; and						
	e. Audit report on user access for EMR (Reference: General Hospital Operational Policy 2025).						
	2. Adherence to relevant Patients and Family Rights standards (refer to Standard 6).						
CRITERION 7.3.1.5							
Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.						
CRITERION 7.3.1.6							
a) A single record for every patient is maintained with an integrated recording system by healthcare providers. b) 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	1. A single record system is implemented for inpatient and outpatient; and						
	2. Integrated records are practiced.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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. **Note:** 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. c) For public hospital, option given for single record system i.e. the following: i) Single record (1 patient, 1 folder) include Inpatient, Outpatient (Emergency Department, Specialist Clinics, Xray Films and all related documents); ii) Merging of Inpatient Records from various disciplines in one folder; iii) Merging of outpatient and inpatient records according to discipline in One folder; and iv) Patient Medical Records that have been compiled using methods a) or b) or c) kept in the Medical Records Department, However if there is constraint on storage							

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space the record can be kept at a 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)							
CRITERION 7.3.1.7							
There is a system for patient identification, cross referencing and a filing system that allows rapid retrieval of records.	1. Policies and procedures for patient identification, cross referencing and a filing system that allows rapid retrieval of records.						
CRITERION 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.	1. On-call roster is available for paper-based systems; and						
	2. 24-hour access electronic system to authorised healthcare providers.						
CRITERION 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.	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);						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	3. Written consent of the patient or authorised next of kin is required for release of medical information to persons not otherwise authorised to receive this information; and						
	4. Patients shall be provided, upon request and in accordance with policy, with timely electronic access to their own medical records (e.g., via patient portals) in a readable and secure format.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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 (if the spouse is eighteen years and above), parent or next of kin where the patient is mentally incapacitated; or c) The parent or guardian where the patient is unmarried and below eighteen years of age **Notes/Explanations:** 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.	1. Written informed consent is taken in accordance with guidelines and regulatory requirements.						
CRITERION 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 and monitored.	1. Policies and procedures on tracing and retrieving of medical records; 2. Medical records movement documentation; and						

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	3. Copy of court order and authorized letter (if applicable).						
CRITERION 7.3.1.13							
The medical practitioners, nurses, and allied health professionals are responsible for the completeness and accuracy of documentation as well as 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 surgery 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; and d) All records are indexed and coded within one month of the patient's discharge.	1. Policies and procedures to include (a) to (d);						
	2. Sampling of patient medical records (BHT); and						
	3. Monitoring of timeliness of medical report preparation.						
CRITERION 7.3.1.15							
There is a policy on the retention of medical records and there are guidelines on the	1. Policy and guidelines on the retention of medical records;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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).	2. Records on medical records disposal; and						
	3. On-site observation on storage of medical records.						
CRITERION 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.	1. Policies, procedures and guidelines on data and information to be collected, analyzed and utilized by the Management.						

Standard 7.3.2
Accessibility of digital care services

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 7.3.2.1 (CORE)							
The Facility shall ensure that the use of digital care services does not disadvantage patients or service users who are unable to access or use digital platforms, by providing alternative modes of care and facilitating digital inclusion where possible. Mitigation strategies to address the digital divide, especially for vulnerable populations, shall be documented and periodically reviewed for effectiveness.	1. The Digital Inclusion Policy, to provide documented guidelines for equitable digital access;						
	2. Minutes of Meeting, to serve as evidence that governance has reviewed digital access strategies.						
	3. Patient & Staff Feedback Surveys, to gather input on the accessibility of digital care.						
	4. Utilization Reports, to show when and why patients were offered or used non-digital alternatives to care (e.g., face-to-face or telephone						

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	services and other forms of communications).						

Standard 7.3.3
Safety and Security of Patient Data and Information in Electronic Communication

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 7.3.3.1 (CORE)							
The Facility shall ensure that all patient-related data and information communicated electronically, including through mobile devices, messaging platforms, email, hospital information systems, or other digital channels, are protected against unauthorized access, misuse, loss, or breach.	1. Policy and procedure on the safety and security of patient data communicated electronically (mobile devices, email, messaging apps, social media platform etc.);						
	2. The policy complies with legal and regulatory requirements (e.g., PDPA 2010, medical ethics, and confidentiality laws);						
	3. Bring-Your-Own-Device (BYOD) protocol for use of personal or mobile devices in communicating patient information (e.g., restrictions, approved platforms, data wiping policies); and						
	4. Staff training and awareness programmes on confidentiality, secure communication, and ethical use of mobile/electronic devices when communicating patient data and information.						

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TOPIC 7.4
FACILITIES AND EQUIPMENT

Standard 7.4.1
Adequate physical facilities and equipment are available for the efficient operations of the HIMS Services.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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. Safety features and access control for authorized personnel; and						
	4. Policy on distribution of medical records addresses the issues of confidentiality and security.						
CRITERION 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.	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, server room or data centre; and						
	3. Easy access and clear exit routes.						
CRITERION 7.4.1.3							
There is sufficient space for storage needs.	1. Paper based system;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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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.	2. On-site observation of the active and inactive medical records storage:						
		a. Electronic system;					
		b. Adequate storage space in the server(s) or certified cloud storage; and					
		c. Off-site back-up system or Disaster Recovery Centre (DRC) is available.					
CRITERION 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.	1. Access control to areas for active and inactive medical records storage;						
	2. Records on medical records movement from the storage areas; and						
	3. An appropriate fire suppression system is in place.						
CRITERION 7.4.1.5							
There shall be a system to control the access to the HIMS Services facility.	1. Security system to control the access to HIMS Services facility, e.g. closed- circuit television (CCTV), security guard, electronic access system, etc.						
CRITERION 7.4.1.6 (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care.						

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TOPIC 7.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

Standard 7.5.1
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.

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CRITERION 7.5.1.1							
There are periodical planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the HIMS Services. The process includes the following: a) Planned activities; b) Data collection; c) Monitoring and evaluation of the performance; d) Action plan for improvement; e) Implementation of action plan; and f) Re-evaluation for improvement g) Innovation	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; and						
	5. Records on innovation if available.						
CRITERION 7.5.1.2							
The HOS has assigned the responsibilities for planning, monitoring and managing safety and performance improvement activities to appropriate individuals/personnel within the respective services.	1. Minutes of meetings;						
	2. Letter of assignment of responsibilities; and						
	3. Job description.						
CRITERION 7.5.1.3							
The Head of HIMS Services shall ensure that the staff are trained	1. System for incident reporting is in place, which include:						

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and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the PIC or Hospital Director of the Facility. Incidents reported with moderate to severe outcome shall have had Root Cause Analysis (RCA) done and action taken within the agreed time frame to prevent recurrence.	a. Training of staff;						
	b. Policy on incident reporting;						
	c. Methodology of incident reporting; and						
	d. Register/records of incidents.						
	2. Completed incident reports;						
	3. RCA;						
	4. Corrective and preventive action plans;						
	5. Minutes of meetings;						
	6. Acknowledgement by HOS and PIC or Hospital Director; and						
	7. Feedback given to staff regarding incident reporting.						
CRITERION 7.5.1.4 (CORE)							
There is tracking and trending of specific performance indicators not limited to but at least four (4) 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	1. Specific performance indicators monitored, verified, and analysed;						
	2. Records on tracking and trending analysis; and						
	3. Remedial measures taken where appropriate.						

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Indicators Version 7.1 2019 Secondary and Tertiary Care (Public & Private) Facility: ≤ 4 weeks Primary Care Facility: ≤ 2 weeks). a) Percentage of case summaries that were dispatched within 72 hours of discharge: **(Target: 95%)** (*Reference: National Indicator Approach Version 5.0).*							
CRITERION 7.5.1.5 (NEW)							
The Services participates in the Facility's safety culture assessment. The results are utilized by Service leadership to inform and guide efforts to improve the culture of safety within the Service.	1. Safety Culture Survey for staff.						
CRITERION 7.5.1.6							
Feedback on results of safety and performance improvement activities are regularly communicated to the staff to promote transparency, shared learning, and active engagement in improvement initiatives.	1. Results on safety and performance improvement activities are accessible to staff through education sessions, meetings and digital communications.						
CRITERION 7.5.1.7							
Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.	1. Documentation on performance improvement activities and performance indicators; and						
	2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						

TOPIC 7.6
SPECIAL REQUIREMENTS

Standard 7.6.1
An accurate patient's medical record is maintained to facilitate optimal patient care, risk mitigation and allow for evaluation of the care provided.

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CRITERION 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; and e) Carrying out concurrent or retrospective evaluation of patient care.	1. Sampling of medical records to ensure (a) to (e) are evidenced in medical records; and						
	2. Audit on quality medical record documentation - sampling is scheduled for at least once in two (2) years. **Reference:** (Manual Audit Rekod KKM Terbitan).						
CRITERION 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.	1. Sampling of medical records to validate the following:						
		a. Only healthcare professionals made entries to the records; and					
		b. Each entry is dated with time and signed by the care provider with name and designation written, typed or stamped.					

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CRITERION 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.	1. Sampling of medical records (paper based/electronic system) to be provided by the medical records staff for surveyor's validation.						
CRITERION 7.6.1.4 (CORE)							
Only the abbreviations and symbols which have been approved by the Medical Records Committee are used.	1. Abbreviations and symbols list which have been approved by the Medical Records Committee; and						
	2. Sampling of medical records on-site to validate compliance to the abbreviations list.						
CRITERION 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.	1. Completeness of documents in medical records, e.g. laboratory report, referal letter, etc.						
CRITERION 7.6.1.6							
Entries to the medical record shall be timely and made in a way that prevents unauthorized alteration.	1. Sampling of medical records on validation of timeliness of entries; and						
	2. On-site observation on practices.						
CRITERION 7.6.1.7							
Corrections which are dated and initiated by the author are only made to the medical record by the	1. Policy on correction of entries in medical records;						

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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.	2. Sampling of medical records to ensure compliance with the above policy; and						
	3. Sampling on the healthcare professional.						
CRITERION 7.6.1.8							
The Facility shall develop and implement a contingency plan which shall include disaster recovery plans (DRP).	1. Five (5) things to be in place in the DRP:						
	a. Identify the organizations critical functions and infrastructure;						
	b. Create emergency response policies and procedures;						
	c. Document back up and restoration process; and						
	d. Perform routine tests and drills.						
CRITERION 7.6.1.9							
Data in Electronic Medical Record (EMR) shall be stored for 7 years and all of it shall be retractable at any point	1. Recovery Plans are available which includes:						
	a. Data backup;						
	b. Disaster recovery plan ;						
	c. Business Continuity Plan (BCP); and						

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	d. An emergency mode operation (EMOP) – An EMOP contains a process that enables organisation to continue to operate in the event of disaster or system failure.						

Standard 7.6.2
Each patient's medical record shall contain appropriate information on the patient and treatment provided.

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CRITERION 7.6.2.1							
There are adequate particulars to identify the patients, including - a) A unique medical record number or reference; b) NRIC, passport number or other ID; c) Name in full; d) Address; e) Date of birth; f) Gender; and g) Person and contact details to notify in an emergency. h) 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.	1. Sampling of medical records addressing items (a) to (h);						
	2. The admission form is completed at the time of admission or when the relevant information is available; and						
	3. Sampling of medical records to validate entry of alert notation.						

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CRITERION 7.6.2.2							
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; d) Examination; e) Assessment including results of investigations; f) Observation; g) Treatment and care plan.;and h) Provisional diagnosis by admitting medical practitioner.	1. Sampling of medical records to ensure (a) to (h) are documented in the medical records.				-		
CRITERION 7.6.2.3							
Drug orders are written directly in the drug prescription form in the patient's medical record by medical practitioners.	1. Drug prescription written by a medical practitioner; and						
	2. Sampling of medical records to verify the above.						
CRITERION 7.6.2.4							
Therapeutic orders and orders for special diagnostic tests are documented in the patient's medical record.	1. Sampling of medical records to verify entry of therapeutic orders and orders for special diagnostic tests.						
CRITERION 7.6.2.5							
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	1. Chronological integrated notes from medical, nursing and paramedical staff noted in samples of medical records.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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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.							
CRITERION 7.6.2.6							
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; and h) Surgeon's name and signature including name of assistant where applicable.	1. Sampling of medical records to verify operative report addressing items (a) to (h).						
CRITERION 7.6.2.7							
The patient's medical record contains information particularly relating to anesthesia, including - a) Date, time and duration; b) Informed consent of anesthesia; c) Evidence of a preoperative assessment by an anesthetist, preferably by the attending anesthetist; d) Drugs and doses given during anesthesia and route of administration;	1. Samplings of medical records and verify the notes containing anesthetic report addressing items (a) to (h).						

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e) Monitoring data; f) Intravenous fluid therapy, if given; g) post anesthetic instructions, where appropriate; and h) Name and signature of attending anesthetist.							
CRITERION 7.6.2.8							
All diagnoses and procedures are recorded using relevant terminology of a current revision of the International Classification of Diseases (ICD).	1. Sampling of medical records indicating current ICD.						
CRITERION 7.6.2.9							
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 Note 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 hospitalization. **Notes/Explanations:** A referral letter shall accompany the patient being transferred to another facility with a copy filed in the patient's medical record.	1. Sampling of medical records containing discharge summary that address items (a) to (f).						

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For public hospitals, only discharge notes are allowed to be given to any patient upon discharge. (Reference: Surat Arahan Bil KKM 87/P1/11/(29) Jld 7 bertarikh 12 Nov 2010)							
CRITERION 7.6.2.14							
For cases undergoing autopsy, a preliminary post-mortem finding shall be recorded in the patient's medical record within 72 hours. The final post-mortem report, including the certified cause of death where applicable, shall be completed and filed in the medical record within 12 weeks of the autopsy. **Reference:** 1. National Policy for Forensic Medicine Services, 2025 2. CliSQI (Medical Programme) Technical Specifications 2025	1. Sampling of medical records to verify that preliminary post-mortem (PM) findings are documented in accordance with local SOP, and that forensic autopsy reports for police/medico-legal cases are prepared by the medical officer who performed the PM within nationally defined turnaround times (e.g., ≤12 weeks per MOH CliSQI), with documented justification for exclusions/delays (such as pending laboratory results, skeletonised remains, mass disasters).						

Standard 7.6.3
Governance, Ethical Use, and Continuous Monitoring of Artificial Intelligence in Patient Care.

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CRITERION 7.6.3.1							
The Facility shall ensure that all AI systems including generative AI used in care complies with national or regional AI regulations. **Reference:** Garis Panduan Pengadaptasian Kecerdasan Buatan (AI) Untuk	1. Documented inventory of AI tools in use with corresponding compliance references;						
	2. Endorsed institutional and national AI policy referencing national laws or ethical standards Garis Panduan Pengadaptasian Kecerdasan						

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Sektor Awam 2025 oleh Jabatan Digital Negara	Buatan (AI) Untuk Sektor Awam 2025 oleh Jabatan Digital Negara; and						
	3. Policies are in place to address the entire AI system lifecycle: pre-procurement validation, change management for algorithm updates, and decommissioning, including data handling.						
CRITERION 7.6.3.2							
The Facility shall monitor and evaluate the safety, accuracy, biasness, ethics and clinical impact of AI systems, with appropriate risk mitigation processes in place.	1. AI Tools Register (clinical, operational, administrative); and						
	2. Periodic audit of AI algorithms for potential bias (e.g., across demographic groups) and document mitigation strategies to ensure equitable outputs.						
CRITERION 7.6.3.3							
Staff shall be consulted before deployment of AI systems, and training shall be conducted to ensure competent and safe usage.	1. Records of stakeholder consultation (meeting minutes, staff feedback); and						
	2. AI-specific training logs, modules, and evaluation records.						
CRITERION 7.6.3.4							
The Facility shall define and document accountability for AI-assisted decisions, ensuring human oversight is preserved. Where AI systems support clinical decision-making, there shall be a policy on the level of explainability required (e.g., factors influencing a	1. Organization chart, role matrices, or SOPs outlining decision responsibility in AI-supported contexts;						
	2. Clinical governance documents confirming accountability assignments; and						

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risk score) and how the AI output is integrated into, rather than replaces, the clinical decision-making process.	3. (TOR/Job Description/Policy).						
CRITERION 7.6.3.5							
The Facility shall inform patients or service users when AI systems are used in their care, particularly where it influences diagnosis or treatment.	1. Standardized patient information leaflets, consent forms, or clinical notes disclosing AI use and acknowledged by patients/service users including disclosure triggers, patient questions, and documentation (including consent where applicable); and						
	2. Approved patient communication protocols addressing AI use, including disclosure standards, staff responsibilities, and documentation requirements within the medical record or digital care platform.						

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Standard 7.6.4 (NEW)
Adoption of Emerging and Connected Health Technologies.

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CRITERION 7.6.4.1							
The adoption of novel connected health technologies (e.g., Internet of Medical Things (IoMT) devices, ambient sensors, robotic process automation) shall be governed by a risk-assessment framework that evaluates: a) Clinical efficacy, b) Data privacy, c) Cybersecurity, d) Workflow integration, and e) Ethical impact prior to deployment. In alignment with the principles outlined in this standard.	1. A documented dossier for each emerging technology, proving a comprehensive risk assessment was completed, which may include: a. Clinical validation reports and outcome metrics (Efficacy); b. Data flow diagrams and privacy impact assessments (Privacy); c. Vendor security attestations and network plans (Cybersecurity); d. Staff training records and workflow integration maps (Workflow); and e. An equity assessment with ethics committee review minutes (Ethical Impact).						

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SERVICE SUMMARY	
OVERALL RATING :	-
OVERALL RISK :	-

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SERVICE STANDARD 08: EMERGENCY SERVICES

PREAMBLE

The Facility shall provide Emergency Services, which shall be accessible and operational on a 24-hour basis. This includes the integration of Prehospital Care Services (PHCS), which involve the delivery of medical care to patients outside of healthcare facilities prior to arrival at the hospital. 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.

TOPIC 8.1
ORGANISATION AND MANAGEMENT

Standard 8.1.1
The Emergency Services including Prehospital Care Services (PHCS) 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.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

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CRITERION 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,	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 are measurable in line with the Facility statements available, endorsed and dated;						
	3. Evidence of planned reviews of the above statements (at least once in 3 years or in the event of any major changes); and						

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reviewed and revised as required accordingly and communicated to all staff.	4. Achievement of goals and objectives are monitored, reviewed and revised accordingly.						
CRITERION 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; and 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 Emergency Services, consultants, medical practitioners and staff of the Emergency Services;						
	2. Organisational chart of the service is endorsed, dated and accessible; and						
	3. The organisation chart is revised when there is a major change in any of the items (c)(i) to (iv).						
CRITERION 8.1.1.3							
Staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters	1. Minutes are accessible, disseminated and acknowledged by the staff;						
	2. Attendance list of members with adequate representation of the service;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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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.	3. Frequency of meetings are as scheduled; and						
	4. Matters requiring action are taken, reported and documented. Pending matters are accounted for and pursued.						
CRITERION 8.1.1.4							
The Head of the Emergency Services is involved in clinical governance and patient management.	1. Appropriate meetings for the department, unit or committee are chaired by Head of Emergency Services; and						
	2. Clinical processes are endorsed by the Head of Emergency Services.						
CRITERION 8.1.1.5							
The Head of Emergency Services is involved in the planning, justification and management of the resources and budget (where applicable) of the services.	1. Minutes of Facility-wide management meeting;						
	2. Documented evidence on budget and resources (staffing, equipment, etc) request and allocation for the service; and						
	3. Approved budget and resources.						
CRITERION 8.1.1.6							
The Head of the Emergency Services is involved in the appointment and/or assignment of the staff.	1. Records on staff interview (if applicable);						
	2. Appointment/Assignment letter of Head of Service;						
	3. Job description of Head of Service;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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	4. Records on staff deployment; and						
	5. Duty roster						
CRITERION 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.	1. Records are available but not limited to the following:						
	a. Workload/Census that includes total attendance (total and by zone categories), type of cases, disposition;						
	b. Annual report;						
	c. Accident/incident reports;						
	d. Staffing number and staff profile;						
	e. Staff training records; and						
	f. Data on performance improvement activities, including performance indicators.						
CRITERION 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	1. Valid letter of intent or request/posting and assigned supervisor (for non-academic healthcare institution);						
	2. Ratio of Clinical Instructor (CI) and students are compliant to regulatory and professional body guidelines; vand						

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responsibilities of all parties including: a) Time period; b) Liability; c) Terms of contract review; d) Accountability for training and clinical practice.	3. Student allocation roster or programme.						
CRITERION 8.1.1.9 (NEW)							
The Head of Services shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	1. Documented and approved BCP for unanticipated situations;						
	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment.						
	3. Clear actions and staff responsibilities during disruption;						
	4. Record of drills or tests, with follow-up actions, if conducted; and						
	5. Review of Risk Register.						

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Standard 8.1.2
CONTINUITY OF CARE
The emergency services 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.

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.

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CRITERION 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; and d) continuity of care is ensured throughout this process;	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; and						
	3. Ambulance transfer form, in-transit and hand-over records.						

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CRITERION 8.1.2.2 (NEW)							
Close working and formal arrangements shall exist between the Emergency and Prehospital Care Services and all relevant stakeholders; The service shall maintain integrated workflows: a) Internally with: i) Other clinical services of the Facility; ii) Support services including cleansing, security; iii) Non-clinical functions of the Emergency Services, i.e. reception, registration/ payment/billing and clerical services. b) Externally through: Formal linkages with external entities to facilitate regional healthcare delivery and emergency response: i) Other local healthcare agencies, feeder clinics, and facilities within the Facility's defined catchment area. ii) The Malaysian Emergency Response System (MERS) Response Centers, respective Agency Dispatch Centers and other Ambulance Service Centers within the	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; and 3. Relevant documents on coordination, policy, Memorandum of Understanding or Agreement.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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designated catchment area. iii) Local Disaster Response Agencies.							
CRITERION 8.1.2.3							
When ambulance services or other patient transport services is utilised (including out-sourced services): 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	1. Ambulance transfer form and records;						
	2. Relevant documents on coordination, policy, Memorandum of Understanding or Agreement; and						
	3. Validation on continuity of physician's orders during transport from staff interview.						
CRITERION 8.1.2.4 (NEW)							
The Emergency Services shall state its role in internal and external emergency or disaster plans of the Facility (or for the community), e.g., Emergency Response Team including Internal Disaster Response, mass casualty incident.	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. Evidence of a disaster operations plan describing its role(s) in a disaster. The document at minimum shall contain the following points: a. Deployment strategy;						

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	b. Incident command; c. Medical command; d. Triage method; e. Clinical care at scene; f. Transportation logistics; and g. Communications with healthcare Organization.						
	4. Records on participation in simulations (tabletop or full-scale) to practice the content of the disaster operations plan; at minimum, once per year; and						
	5. Record on simulation or real event post mortem review and improvement strategies, at minimum on the: a. Ability to implement the plan; and b. Adequacy of logistical resources, tools, materials and supplies used to implement the plan.						

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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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 8.2.1.1 (CORE)							
The Head of the Emergency Services shall be an emergency physician who is an 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 that do not have an on-site Emergency Physician shall be supported by a visiting Emergency Physician. In the absence of a Resident Emergency Physician, the Emergency Services shall be supervised by a Resident Specialist. Number/frequency of emergency physician visit depend on capacity and capability of state determined by head of service of the state or by PIC.	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. Certification;						
	3. Training and competency records;						
	4. Valid professional Annual Practising Certificate (APC) and registered with NSR; and						
	5. Documentation of visits of the Emergency Physician.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Appointment/assignment letter for Head of Service; and						
	2. Description of duties and responsibilities.						
CRITERION 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.	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 and deployment; and						
	5. Census and statistics.						
CRITERION 8.2.1.4							
There are written and dated specific job descriptions for all categories of staff that include:	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;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and vi) Statutory Regulations. e) Administrative and clinical functions.	2. Job description includes specialisation skills;						
	3. Relevant privileges granted where applicable;						
	4. The nature and scope of work of each staff is specified; and						
	5. The job description is acknowledged by the staff and signed by the Head of Service and dated.						
CRITERION 8.2.1.5							
Personnel records on training, staff development, leave and others are maintained for every staff. **Note**: Staff personal records may be kept in the Human Resource Department as per Facility policy.	1. Staff personal records include:						
	a. Staff biodata;						
	b. Qualification and experience;						
	c. Evidence of current registration;						
	d. Training record;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	e. Competency record and privileging;						
	f. Leave record;						
	g. Confidentiality agreement.						
CRITERION 8.2.1.6							
There are continuing education and training needs assessment activities for all staff including medical practitioners which provides the knowledge and skills required for staff to maintain competency and also to pursue professional interests for current and future changes in practice.	1. Training needs assessment is carried out and gaps identified;						
	2. Training calendar includes in-house/external courses/ workshop/conferences;						
	3. Contents of training programme and module;						
	4. Staff development plan and training records on continuing education activities are kept and maintained for each staff; and						
	5. Certificate of attendance/degree/post basic training.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 8.2.1.7							
There is a structured orientation programme for all newly appointed, contracted and outsourced staff to the Emergency Services including medical practitioners and for those new to specific areas that include but not limited to the following: <u>General</u> a) Vision and mission of the Facility b) Organisation chart and reporting structure of the Facility c) Environment and facility safety policies and procedures including sustainability practices d) Infection control policies and procedures e) Policies for performance management, patient safety (IPSG/MPSG) and risk management f) Ethical practices and code of conduct including medicolegal awareness g) Management of aggression, violence and harassment h) Patient and family rights <u>Services</u> a) Goals, objectives and organisational structure of Emergency Services	1. Policy requiring all new staff to attend a structured orientation programme;						
	2. There is an Emergency Services orientation programme with relevant topics not limited to topics covered from (a) to (q); and						
	3. Attendance list.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
b) Policies and procedures relevant to Emergency Services c) Working instructions for patient care d) Service continuity plan for Emergency Services in response to internal and external disasters <u>Job-specific</u> a) Explanation of particular duties and functions b) Explanation of the methods of assigning clinical care and the standards of clinical practice c) Handover communication d) Training in basic/advanced life support techniques e) Technology and equipment use including artificial intelligence, digital care and robotics.							
CRITERION 8.2.1.8							
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.	1. Performance appraisal for staff including medical practitioners is completed and acted upon appropriately upon probationary period and as an annual exercise.						

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Standard 8.2.2 (NEW)
The emergency services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the emergency services staff, ensuring a safe and healthy work environment.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 8.2.2.1 (CORE) (NEW)							
The emergency services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being. a) A health-promoting environment, e.g., stress management, burnout, staff engagement opportunities, workload monitoring, management of work life balance, healthy, lifestyle programmes e.g. Workplace Wellness Programs, Community-Based Health Initiatives; b) Staff shall be provided with appropriate supervision, support, and advice e.g., mentor mentee program; and c) There shall be clear procedures for the effective management of underperformance e.g., feedback on performance review or performance appraisal report.	1. The promotion of staff well-being may involve the following:						
	a. Evidence of a health promoting environment e.g., workplace wellness programme;						
	b. Evidence of proper supervision of staff; and						
	c. Evidence of staff appraisal programme with feedback on underperformance.						
CRITERION 8.2.2.2 (CORE)							
The emergency services shall establish a safe mechanism for emergency services staff to express grievances, provide	1. Emergency services staff suggestions and grievance reporting and processing mechanisms are available;						

suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety.	2. The resolution of workplace issues may involve the following: a. Measures and evidence of emergency services staff protection including whistleblowers against violence, bullying, and harassment e.g., awareness campaigns, anonymous reporting channel, Whistleblower policy; and b. Documented policies and procedures for violence activation and emergency services staff protection.					
CRITERION 8.2.2.3 NEW						
A system shall be created to gather emergency services staff feedback such as burnout about their workplace experience which shall be analysed and used to make improvements that enhance the work environment, emergency services staff satisfaction, and organisation culture.	1. Emergency services staff feedback (e.g., minutes of sessions or nursing staff satisfactions survey): a. Evidence of action or improvement taken.					
CRITERION 8.2.2.4 (NEW)						
The emergency services shall track sick leave and emergency services staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning.	1. Evidence that workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments. The results shall be used to create focused actions that improve emergency services staff well-being, solve problems, and					

	help retain emergency services employees.						

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TOPIC 8.3
POLICIES AND PROCEDURES

Standard 8.3.1
A reliable and consistent triage system shall be established and used to assess all patients on arrival.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Triage flow and standard operating procedures (SOP);						
	2. Triage training certificate and log book; and						
	3. Records on continuing medical education activities for staff.						
CRITERION 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.	1. Zoning of clinical areas is reflective of patient severity/acuity; and						
	2. Triage category is observed and complied in practice.						
CRITERION 8.3.1.3							
Action plans and policy for the appropriate cohorting, and isolation of patients suspected or confirmed with infectious disease and decontamination of patients who are exposed to hazardous material shall be available.	1. Policy on management of infectious diseases and outbreak- cohorting, isolation and decontamination of patients suspected or confirmed with infectious disease or expose to hazardous material in Emergency Services;						
	2. Identified areas/structures for cohorting, isolation and decontamination of patients suspected of infectious disease or						

	expose to hazardous material in Emergency Services; and						
	3. Area use for isolation of patient suspected or confirmed with infectious disease must be compliance to Infection Prevention and Control (IPC), WHO and engineering requirement by Ministry of Health, Malaysia.						

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.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 8.3.2.1 (CORE)							
There are written policies and procedures for the Emergency Services including PHCS 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.	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; and						
	4. The policies and procedures are endorsed and dated.						
CRITERION 8.3.2.2							
Policies and procedures are developed in collaboration with staff, medical practitioners, Management and where required with other external service	1. Minutes of committee meetings on development and revision on policies and procedures;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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providers and with reference to relevant sources involved. Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.	2. Minutes of meeting with evidence of cross reference with other departments; and						
	3. Documented cross departmental policies.						
CRITERION 8.3.2.3							
Current policies and procedures are communicated to all staff.	1. Training and briefing on the current policies and procedures/Minutes of meetings; and						
	2. Circulation list and acknowledgement.						
CRITERION 8.3.2.4 (CORE)							
There is evidence of compliance with policies and procedures including Patients and Family Rights.	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; and						
	d. Practices in line with established policies and procedures evidenced upon on-site inspection.						
	2. Adherence to relevant Patients and Family Rights standards (refer to Standard 6);						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 8.3.2.5							
Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By- Laws and statutory requirements are accessible to staff.	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.						
CRITERION 8.3.2.6							
There will be a working relationship between the emergency department and relevant emergency services such as police, fire and rescue, 999, civil defense, other ambulance agencies and/or local disaster agencies etc	1. Minutes/report of inter departmental/ inter agency meetings and training: such as disaster table top exercise, interagency life support training etc; and						
	2. Shared workflow and standard operating procedures, i.e. for abuse cases under One Stop Crisis Center (OSCC) where applicable, external and internal disaster response plan and etc.						
CRITERION 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.	1. Patient identification policy, process and workflow;						
	2. Patient identification (medical record number); and						
	3. Patient identification tag for unconscious and unknown identity patients.						
CRITERION 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	1. Patient care forms;						
	2. Patient medical records; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
appropriate, response to care is recorded by the care provider; signed, dated and designation documented.	3. Drug prescription form.						
CRITERION 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.	1. Appropriateness of triage category for seriously ill patient;						
	2. Policy for observation and monitoring according to patient severity and care area; and						
	3. Nursing care notes and documentation.						
CRITERION 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.	1. Standard operating procedures on patient transfer process for intra or out of services movements; and						
	2. Verification of staff escort credentials						
CRITERION 8.3.2.11							
For Emergency Services having patients cared for extended periods, such as a dedicated patient observation area or short stay unit, there shall be a documented policy/ guidelines on the operational definitions, clinical criteria, permissible	1. Operational policy for observation area/short stay unit or ward on the operational definitions, clinical criteria, *permissible duration of stay and accountability; and						
	2. Patient care documents ie: regularity of doctor review and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
duration of stay and accountability.	management, nursing care report incl. vital sign monitoring etc.						
CRITERION 8.3.2.12 (CORE)							
When admitted patients remain in the Emergency Services environment beyond a reasonable period due to access block, this is considered a situation that is, or could potentially lead to, a shortfall in care within the facility. Nevertheless, clinical care continuity is maintained, and patient needs and rights are upheld.	1. Institution policy/standards for unintentional extended stay in the Emergency Services environment, its monitoring system and contingency plan to ensure clinical care, patient needs and rights are met;						
	2. Method of monitoring of the access block and its impact to Emergency Services such as overcrowding;						
	3. Length of stay performance / statistics for admitted patient in emergency services;						
	4. Patient care documents ie: regularity of doctor review and management, nursing care report incl. vital sign monitoring etc; and						
	5. If the issue persists, a collaborative effort involving the relevant services shall be initiated and proposed to management for resolution.						
CRITERION 8.3.2.13							
The Emergency Services shall implement policies and procedures to ensure the safety and protection of staff from verbal and physical violence.	1. Documented policy on prevention and management of workplace violence;						
	2. Training records of staff on method in managing violent patients using techniques such as de-escalation						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	techniques and handling of aggressive behavior; and						
	3. Emergency Services records and monitor trending of incident reports regarding verbal and physical violence to staff.						

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TOPIC 8.4
FACILITIES AND EQUIPMENT

Standard 8.4.1
Services are equipped with appropriate facilities and lifesaving equipment to deliver safe, effective, and efficient emergency care. A key component of this service includes the One Stop Crisis Centre (OSCC), which incorporates the Integrated Suspected Child Abuse and Neglect (SCAN) program, ensuring specialized care for high-risk cases.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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 (red zone); d) Semi-critical area (yellow zone); e) Non-critical area (green zone); f) Procedural and specialty care area for example: plaster room, minor operation theatre and etc.; g) Patient isolation and decontamination area; and h) Others (when applicable) - for example but not limited to:	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. In the event, if the patient capacity exceeds the clinical area at any one time, an action plan shall be made available (Refer to 8.3.2.12 evidence 5); and						
	4. Patient journey experience (interview).						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
i) Ambulance Communication Centre ii) Ambulance drop zone and access iii) Point of Care Testing Area iv) Respiratory Hemodynamic Area i) Storage (consumable, equipment and disaster) cross reference with standard 2 for disaster, common storage area.							
CRITERION 8.4.1.2 (NEW)							
There are adequate and appropriate facilities and equipment for One Stop Crisis Centre (OSCC) with Integrated Suspected Child Abuse and Neglect (SCAN) team area.	1. The OSCC shall have designated secure private space with soundproof rooms, toilet amenities, counselling facility, child friendly space, and discreet entry/pathway to ensure confidentiality;						
	2. There shall have dedicated policies and procedures for OSCC to include but not limited to:						
	a. Multi-Disciplinary Team – Includes medical staff (doctors/nurses), social workers, police/law enforcement (on-site or on-call), and legal aid officers;						
	b. Essential Medical & Forensic Supplies – Rape evidence kits, emergency contraceptives, Post Exposure Prophylaxis (PEP), STI treatment, and wound care supplies;						
	c. Confidential Record-Keeping – Secure digital/physical						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	documentation with restricted access;						
	d. Referral Network – Formal linkages with shelters, legal aid, and long-term support services;						
	e. Privacy & Security Measures – Surveillance, trained security personnel, and confidentiality safeguards;						
	f. Staff Training – Regular sessions on trauma-informed care, forensic evidence, and legal updates;						
	g. Community Collaboration – Partnerships with NGOs, women's groups, and government agencies; and						
	h. Monitoring & Evaluation – Anonymous data tracking and survivor feedback mechanisms.						
CRITERION 8.4.1.3							
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.	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.); and						
	4. Easy access and clear exit routes.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 8.4.1.4							
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); and						
	2. Certificates of calibration and standards compliance, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc.						
CRITERION 8.4.1.5 (CORE)							
There is evidence that Emergency Services adheres to Facility comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.	1. Planned Preventive Maintenance records such as schedule, stickers, etc;						
	2. Planned Replacement Programme where applicable;						
	3. Complaint records; and						
	4. Asset inventory.						
CRITERION 8.4.1.6							
Where specialized equipment is used, there is evidence that only staff who are trained and privileged by the Facility to operate such equipment. Examples of specialized	1. User training records;						
	2. Competency assessment record;						
	3. Letter of authorisation; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
equipment (but not limited to) are: a) Point of Care Test (Blood Gas Analyzers, Full Blood Count, Coagulation Test and Biochemistry Test); b) Rapid Fluid Infusors; c) Mechanical CPR Device; d) Ventilator (transport and non-transport); e) Intra Arterial Blood Pressure Monitoring System; f) Bronchoscopy / Fibreoptic Intubation Scope; and g) Anaesthethic Gas Machine	4. List of staff trained and privileged to operate specialised equipment.						
CRITERION 8.4.1.7							
Where Artificial Intelligence (AI) Technology is incorporated into medical equipment or clinical practice, there is evidence that only staff who are trained and privileged by the Facility to operate such technology.	1. User training records;						
	2. Competency assessment record;						
	3. Letter of authorisation; and						
	4. List of staff trained and privileged to operate specialized equipment.						
CRITERION 8.4.1.8 (CORE)							
The Emergency Services are equipped with the minimum equirements in terms of equipment. Additional equipment may be required to meet the goals and objectives of the Emergency	1. On-site observation on availability of items (a) to (o); and						
	2. Credential and privileged medical officer in performing a (iii), c(i), d (i), l (ii).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Services and the Facility depending on the level and scope of Emergency Services. Minimum requirements are based on equipment and other functionalities: a) Airway Management devices such as: i) Adjuncts:- oropharyngeal airway, nasopharyngeal airway; ii) Endotracheal Intubation Equipment; and 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							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
(manual/ mechanical); and ii) Intravenous fluid delivery devises inclusive volumetric pump and rapid infusions. e) Defibrillator and Emergency Cardiac Care Equipment including: i) 12 Lead ECG machine; ii) Transcutaneous pacing; and iii) Defibrillator with Automated External Defibrillator (AED) capabilities. 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 oximetry, Cardiac Monitoring and temperature; j) Wounds, Soft tissue and Burns Care Sets; k) Point of Care or Bedside (Rapid) Diagnostic Tests or Support including:							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
i) Blood sugar analyzer; ii) Urine analyzer; iii) Full blood count; iv) Arterial blood gas; and v) Rapid Test Kits: dengue test and others. l) Bedside Imaging Devices or Support: i) Access to portable X-ray; and ii) 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; and o) Emergency Patient Care Beds.							
CRITERION 8.4.1.9 (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 - standard list approved by Facility	1. Emergency Services shall have a list of drugs approved by Facility to be stored in Resuscitation Cart and Floor Stock; and 2. On-site observation on availability of items (a) and (b).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
b) Drugs to be kept as floor stock drug with easy availability - standard list approved by Facility							
CRITERION 8.4.1.10 (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care.						

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TOPIC 8.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

Standard 8.5.5.
The Head of Services shall foster high quality performance by involving staff in safety and continuous improvement initiatives, including systematic risk management, active staff involvement and the use of performance data to drive service enhancements. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 8.5.1.1							
There are periodical 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; and f) Re-evaluation for improvement and g) Innovation	1. Planned performance improvement activities include (b) to (f);						
	2. Records, trending and analysis on performance improvement studies and activities;						
	3. Minutes of performance improvement meetings;						
	4. Mortality and morbidity audits with remedial actions;						
	5. Records of performance improvement and remedial actions adoption into training needs, policy, guidelines and standard operating procedures; and						
	6. Records on innovation, if available.						
CRITERION 8.5.1.2							
The Head of Services has assigned the responsibilities for	1. Minutes of meetings discussing progress on improvement activities;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
planning, monitoring and managing safety and performance improvement activities to appropriate individuals/personnel within the respective services.	2. Letter of assignment of responsibilities; and						
	3. Job description.						
CRITERION 8.5.1.3							
The Head of Services shall ensure that staff are trained and that they complete incident reports. These reports shall be promptly reported, investigated, and discussed by the staff with learning objectives, before being submitted to the PIC of the Facility. Where appropriate, according to the Facility matrix, reported incidents undergo an RCA, and corrective and preventive action is taken within the agreed time frame to prevent recurrence.	1. A system for incident reporting is in place and includes the following:						
		a. Training of staff;					
		b. Policy on incident reporting; and					
		c. Register/Records of incidents.					
	2. Completed incident reports:						
		a. RCA;					
		b. Corrective and preventive action plans; and					
		c. Remedial measure.					
	3. Clinical audit including patient safety reviews (e.g., mortality and morbidity review, etc);						
	4. Sentinel Event Investigations with appropriate corrective and preventive actions (CAPA), and oversight by the governing body;						
	5. Grievance Mechanism, both staff and public, including grievance reporting and processing mechanisms are available;						
	6. Minutes of Meetings;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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	7. Acknowledgment by Head of Services and PIC; and						
	8. Feedback and learnings from incident reporting are shared with staff.						
CRITERION 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: a) Mandatory Indicator percentage of inappropriate triaging (under triaging): i) Category Green patients who should have been triaged as Category Red. (Target: ≤0.5%) 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 30minutes (Target: ≥85%) iii) Malaysian Triage Category (MTC) Green seen within 90 minutes (Target: >70%). c) Unplanned return of patient seen at Emergency Department within 24 hours to 72 hours for a similar complaint (sentinel event).	1. Specific performance indicators monitored, verified, and validated;						
	2. Records on tracking and trending analysis;						
	3. Remedial measures taken where appropriate;						
	4. Review any performance indicator over a one-year period:						
	a. Have consistently met or exceeded targets;						
	b. Continue to show persistent SIQ or performance; and						
	c. Acknowledgment by Head of Services and PIC.						
	5. Where applicable, review the target or identify new indicators.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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d) Percentage of Intravenous (IV) Tranexamic Acid given in trauma patients with severe haemorrhage within 60 minutes of first medical contact (Target: ≥70%).							
CRITERION 8.5.1.5							
Emergency Services 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).**	1. Planned performance activities on World Health Organization (WHO) Global Patient Safety Initiatives and Malaysian Patient Safety Goals; and						
	2. Records, trending and analysis on performance studies and activities.						
CRITERION 8.5.1.6 (NEW)							
The Services participates in the Facility's safety culture assessment. The results are utilized by Service leadership to inform and guide efforts to improve the culture of safety within the Service.	1. Safety Culture Survey for staff						

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CRITERION 8.5.1.7							
Feedback on results of safety and performance improvement activities are regularly communicated to the staff to promote transparency, shared learning, and active engagement in improvement initiatives.	1. Results on safety and performance improvement activities are accessible to staff through education sessions, meetings and digital communications.						
CRITERION 8.5.1.8							
Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.	1. Documentation on performance improvement activities and performance indicators; and						
	2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						

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TOPIC 8.6 (NEW)
SPECIAL REQUIREMENT: QUALITY STANDARDS FOR PREHOSPITAL CARE SERVICES
Prehospital Care Services (PHCS) refer to the provision of medical care delivered to patients outside healthcare facilities prior to arrival at a hospital. These services encompass a broad spectrum of conditions ranging from minor illnesses or injuries to life-threatening emergencies, requiring interventions from basic first aid to advanced emergency care delivered at the scene, during transportation, or at public and mass gathering events. PHCS typically begins with an ambulance dispatch system that coordinates emergency response, provides clinical advice or referral when appropriate, and deploys ambulance services or emergency vehicles to deliver care and transport patients to appropriate healthcare facilities.

STANDARDS 8.6.1
An ambulance dispatch service is the first point of contact for PHCS responding by either dispatching emergency vehicles or ambulance to the scene or providing clinical advice or referrals when appropriate.

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CRITERION 8.6.1.1							
Prehospital Care Services shall work with its own local or regional Ambulance Dispatch Service as a centralized communication center that receives request for ambulance service.	1. Prehospital Care Services has an established system or number that can be used as method to request for its service;						
	2. An area or workstation(s) equipped with communications system or technology system which allows monitoring of ambulance service requests received and managed; and						
	3. The area or workstation(s) is adequately staffed by personnel as reflected in the work roster schedule.						
CRITERION 8.6.1.2							
A request triage protocol shall be used by trained staff or dispatchers to assess response needs and clinical acuity of patients for all request received.	1. Documented standardised request triaging policies, procedures, or protocol that is endorsed and dated;						
	2. Evidence of periodic review of policies, procedures and protocols; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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	3. Evidence of training and certification of staff using the protocol.						
CRITERION 8.6.1.3							
Ambulance dispatch service shall have ambulance dispatch prioritization protocol when there are multiple simultaneous request, or mass casualty incident or surge capacity scenario or unplanned service disruption.	1. Documented ambulance dispatch prioritization protocol that is endorsed and dated;						
	2. Evidence of periodic review of the Request Management and Response Plan; and						
	3. Evidence of training and briefing to staff on the current response plan.						
CRITERION 8.6.1.4							
The ambulance services or other patient transport services shall ensure (including out-sourced services): a) The procedure is done in a coordinated manner. b) Medical oversight is provided by the referring facility. c) Continuity of physician directives during the transport is ensured. d) Shall be accompanied by appropriate and competent health care provider.	1. Ambulance transfer form and records;						
	2. Relevant documents on coordination and policy; and						
	3. Validation on continuity of physician's orders during transport from staff interview.						
CRITERION 8.6.1.5							
The Ambulance Dispatch Service is equipped with information and communications technology system that allows it to monitor	1. Evidence management system for individual request record or tracking number;						
	2. Evidence of established communication systems or methods						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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and document response activities which involve the following: a) Request or incident identification. b) Response progress monitoring and documentation from time deployed to completion of response. c) Pre-arrival communication with receiving healthcare organisation; d) Deployment of additional resources either from internal or external resources.	between the Ambulance Dispatch Service with responding team dispatched to site: a. Healthcare organization receiving patients. b. Interagency service that may be required at incident location.						

STANDARDS 8.6.2
CLINICAL CARE OF AMBULANCE SERVICE
Ambulance service response outcome shall be based on clinical assessment of patient's needs incorporating current knowledge of evidence based practices; and adheres to relevant regulations and statutory requirements.

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CRITERION 8.6.2.1							
Clinical personnel shall assess patients using various methods available to them, then prioritize treatment and transport to appropriate healthcare organizations according to urgency, and healthcare service best matched to patients' clinical needs.	1. There is a documented clinical protocol on care rendered by responders consistent with national, state or local health policies; regulatory requirements; and evidence-based practices;						
	2. There is a documented protocol on determination of transport destinations for patients based on						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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	services availability at the organisation; and						
	3. The policies, protocols and procedures are endorsed and dated.						
CRITERION 8.6.2.2							
All patients shall be correctly identified from the first time of contact with Ambulance Service personnel.	4. Patient identification policy, process and workflow utilising various modalities such as: a. Patient identification number (name, NRIC, passport), or request record number. b. Patient identification tag for unconscious and unknown identity patients.						
CRITERION 8.6.2.3							
Prehospital Care Services develop and implement process to improve accuracy of patient or call identification or tagging.	1. Standard operations on patient or request identification of Ambulance Service is matched to Ambulance Dispatch Centre and Destination Hospital Handover;						
	2. There is an operational standard for patient identification in multiple or mass casualty incidents; and						
	3. There is a medical record to document patient care beginning from request, activation, care at scene, transporting and handover at destination hospital.						
CRITERION 8.6.2.4							
Documentation is made in the patient's medical record that care has been given. Clinical care documentation shall include: a) Response time intervals,	1. Prehospital Care Patient care forms or electronic medical record with elements from (a) to (f) above.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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b) Clinical history, assessment and intervention. c) Medication administration. d) Appropriate monitoring. e) Transport decisions; and f) Handover of care to healthcare personnel at receiving organization. The recorded clinical care shall be signed, dated and designation of Ambulance Service personnel documented.							
CRITERION 8.6.2.5							
Prehospital Care Services develops and implement processes to improve verbal communication process from Ambulance Dispatch Centre, Ambulance Service till handover at destination facility.	1. Records of call audits performed at Ambulance Dispatch Centre;						
	2. Customer feedback surveys performed focused on but not limited to: a) Healthcare organizations engage in the service; b) Public engaging the service; and c) Healthcare organization receiving the patients.						
CRITERION 8.6.2.6							
Prehospital Care Services that manage, store and administers medications to patients shall develops and implement process to improve safety of high-alert medications, where applicable.	1. Process of high-alert medication identification;						
	2. Education and training of staff on safe medication administration; and						
	3. Process of medication management during transport for interorganizational patient transport services.						

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STANDARDS 8.6.3: ETHICAL PRACTICE: PATIENT AND FAMILY RIGHTS

A Prehospital Care Services shall establish ethical guidelines that promote appropriate, safe and efficacious Ambulance Dispatch Centre Services; Ambulance Services; and Mass Gathering and Major Events Coverage Services. It shall have policies supporting patients' rights as well informing them of their responsibilities. Prehospital Care Services shall always ensure that the best interests of patients shall prevail when there is a conflict between the business interests and the patients' welfare.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 8.6.3.1							
Informed Consent. Patients are informed on the procedures, intervention and transport destinations.	1. Policies and procedures on methods of informing patients regarding procedures, intervention and determination of transport destination;						
	2. Policies and procedures on managing procedures, intervention or Transportation destination refusal;						
	3. Policy on consent for patients to be photographed; and						
	4. Consent/indemnity form for relative accompanying patient in ambulance (Where applicable).						
CRITERION 8.6.3.2							
Patients and Family Rights. Prehospital Care Services shall have processes that support patient and family rights from the point of accessing care. 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.	1. 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 safe and medically appropriate treatment regardless of race, culture, sex, nationality, or source of payment. b. considerate, respectful, privacy and confidential medical care. c. reasonable information to patients and next of kin about						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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	process, intervention, and determination of transport destination. d. participation in making informed decisions concerning care including the right to refuse proposed treatment against medical advice, experimental care, and participation in research projects. e. appropriate counseling prior to treatment refusal against medical advice. f. administration of pain management where appropriate. g. advice on the approximate cost of treatment prior to the provision of care. h. information regarding financial and other assistance that may be available. i. receipt and itemized statement of all charges. j. information of the responsibilities of patients and families k. When clinically feasible, care provided is considerate and respectful of the patient's personal values, beliefs and religion.						
	2. Evidence that the Person in Charge (PIC) ensures implementation of patient and Family Rights.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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	3. Records on education or training program on Patient and Family Rights to staff.						
CRITERION 8.6.3.3							
Protect Patients Possessions from Theft or Loss. Prehospital Care Services takes measures to protect patients' possessions from theft or loss. Prehospital Care Services communicates its responsibility for the patient's personal possessions brought into its emergency vehicle or ambulance. 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 those patients unable to make alternative safekeeping arrangements and those incapable of making decisions regarding their possessions including those transported without signs of life.	1. There is a policy and process on patient's possessions and records.						
	2. There is a process to safeguard patient's possessions						

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STANDARDS 8.6.4
Prehospital Care Services personnel have ready access to equipment to enable provision of effective and efficient emergency care.

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CRITERION 8.6.4.1							
The Prehospital Care Services have a policy/procedure for checking each vehicle's medical equipment each day, it is to be used. At a minimum, this policy/procedure shall include proper function of durable medical equipment, adequate supply of all equipment, expiration dates on applicable items, and documentation of the check.	1. There is a policy standard on minimum vehicle's and responder's medical equipment each day it is to be used signed by Medical Director;						
	2. Evidence of checking process; and						
	3. On-site observation on availability of items within the checklist.						
CRITERION 8.6.4.2							
The Prehospital Care Services are equipped with the minimum requirements in terms of equipment. Additional equipment may be required to meet the goals and objectives of the Prehospital Care Services and the Facility depending on the level and scope of Prehospital Care. a) There is evidence that the ambulance is equipped and maintained in accordance with Act 586: i) 9th schedule Appendix 1 ii) 9th Schedule Appendix 2 Ambulance equipment	1. On-site observation on availability of items (i) to (xvi); and						
	2. Equipment handling checklist						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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iii) 9th Schedule Appendix 3 Doctor's Bag iv) 9th Schedule Appendix 4 Paramedic's Bag b) Minimum requirements are: i) Fire Extinguisher; ii) A Response bag that could be carried out of the vehicle to patient side; iii) Portable Oxygen Cylinder that could be carried out of the vehicle to patient side with appropriate regulator; iv) Personal Protection Equipment: 1) Eye Goggles; 2) Disposable or sterile gloves ; 3) Shoe covers; 4) Plastic apron or disposable gown; and 5) Face masks with or without face shields. v) Immobilization Equipment (Adults And/Or Pediatrics): 1) Upper Limb immobilizers; 2) Lower limb immobilizers; 3) Pelvic immobilizer; 4) Cervical collar adult; and							

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5) Spine immobilization devices (scoop stretcher or spinal board). vi) Wound management equipment; vii) Disposable dressing kit; viii) Oxygen and ventilation therapy equipment: 1) Portable Oxygen Cylinder Size that could be carried out of the vehicle to patient side with appropriate regulator; 2) Static Oxygen Cylinder Size; 3) Oxygen regulator (with humidifier); and 4) Oxygen delivery devices such as masks or nasal prong (adult and/or pediatrics) ix) Ambulance stretcher with at least 3 straps straps including shoulder straps x) Linen equipment: 1) Bedsheets; and 2) Blankets. xi) Infection prevention & control materials: 1) Sharp's container;							

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2) Yellow hazard disposable bin; and 3) Rubbish disposable bin. xii) Portable suction unit: 1) Rigid or yaunker sucker (adult and/or pediatrics); and 2) Flexible suction catheter (adult and/or pediatrics). xiii) Nasogastric tubes; xiv) Transport monitor: 1) Blood pressure cuff (adult and/or pediatrics); 2) SpO2 probe (adult and/or pediatrics); and 3) ECG leads (3 leads). xv) Automate/ manual defibrillator: 1) Pads (adult and/or pediatrics) xvi) Glucometer							
CRITERION 8.6.4.3							
Prehospital Care Services implements safety procedures on ambulance design and stretcher management to reduce risk of patient harm resulting from fall or accidents.	1. Policy of ambulance driving and safety standards;						
	2. Record on ambulance drivers defensive driving training;						
	3. Records of incident report monitoring of any falls or accidents involving use of ambulance or stretchers; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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	4. Records on investigative and corrective measures implementation of incident report monitoring of any falls or accidents involving use of ambulance or stretchers.						

STANDARDS 8.6.5
VEHICLES MAINTENANCE
The Prehospital Care Services have vehicles that are safe, clean, and reliable for transportation.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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CRITERION 8.6.5.1							
Vehicles are designed and maintained in good working order, in accordance with applicable standards and statutory requirements. All vehicles utilization and maintenance adhere to manufacturer's recommendations.	1. The agency shall have documented guidelines for total weight restrictions for each vehicle;						
	2. The agency shall have a standard operating procedure addressing vehicle cleanliness standards; cleaning required after each patient; and additional cleaning required after transport of patients with or suspected of having communicable diseases;						
	3. Programs shall be in place to provide comprehensive vehicle maintenance;						
	4. Records of preventive maintenance program for all vehicles in accordance with vehicle manufacturer recommendations; and						
	5. Records of unscheduled vehicle maintenance program.						

STANDARDS 8.6.6
QUALITY AND SAFETY OF SERVICES
The Prehospital Care Services shall ensure the provision of high-quality performance with staff involvement in the ongoing safety and performance improvement activities of its scope of service.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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CRITERION 8.6.6.1							
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) Response performance: i) Average Activation Time (< 60 Seconds); ii) 80% of all Priority 1 cases occurring within 15 km of an ambulance standby point will receive an ambulance response within 15 minutes from activation time; and iii) Average Turnaround Time (at ED) (< 30 Minutes). b) 2. Fleet and safety: i) Fleet Availability (> 95%); and ii) Accident Rate (0) c) Hospitals receive pre-arrival notification from Prehospital Care Team for patients suspected of having hyperacute stroke. (80%); and d) 90% patients suspected of having anginal chest pain	1. Specific performance indicators monitored.						
	2. Records on tracking and trending analysis.						
	3. Remedial measures taken where appropriate						

shall have ECG performed prior to arrival to AED.							

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SERVICE SUMMARY	
OVERALL RATING :	
OVERALL RISK :	

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SERVICE STANDARD 9: CLINICAL SERVICES – NON-SPECIALIST SERVICES

PREAMBLE

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. 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:

a) appropriateness of clinical care;

b) unwarranted variation in care that is not explained by the clinical circumstances or personal choices of the medical practitioners in:

i) Overuse of treatments or procedures that do not help patient get better;

ii) Underuse of care;

iii) Misuse (or errors) of doing something incorrectly and harming patients.

The Clinical Services also support environmentally sustainable healthcare and social care, systems for governance, security and monitoring of digital care, mental and physical wellbeing support. In addition to the above, the Clinical Services also conducts teaching and training, audit activities as well as research where applicable. A core focus is on building clinical team resilience, ensuring psychological safety for staff, and delivering equitable care that actively identifies and mitigates disparities in service access and outcomes.

TOPIC 9.1
ORGANISATION AND MANAGEMENT

Standard 9.1.1

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.
A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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	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 are measurable in line with						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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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.		the Facility statements are available, endorsed and dated;					
	3.	Evidence of planned reviews of the above statements (at least once in 3 years or in the event of any major changes);					
	4.	These statements are communicated to all staff (orientation programme, minutes of meeting, etc; and					
	5.	Achievement of goals and objectives are monitored, reviewed and revised accordingly.					
CRITERION 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 hospitals under the cluster/networking initiative.	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 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); and					
	4.	Clustering hospital representation is shown in organisation chart (where applicable).					
CRITERION 9.1.1.3							
	1.	Departmental/Service operational policies that address (a) to (d);					

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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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 multidisciplinary teams, are involved in the formulation of policies and procedures concerning patient care appropriate to the scope of services of the Facility. e) Address the clinical service(s) by healthcare providers from clustering facilities (where applicable) which include privileging, training and monitoring of specific relevant performance indicators	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 including Cluster Management Committee where applicable; and						
	6. Proper and adequate equipment according to current standards and regulatory requirements.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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CRITERION 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.	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; and						
	3. Minutes of Meetings.						
CRITERION 9.1.1.5 (CORE)							
The Head of Clinical Services has: c) To be a registered medical practitioner (where there is resident	1. Letter of assignment from governing body;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
specialist in the service, the specialist shall resume as the head of Service). d) Representation of the Service in committees and subcommittees where relevant; e) Representation of the Service in clinical staff liaison meetings; f) Involvement and provide regular input to the Senior Management Team	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; and						
	4. Minutes of meeting of Senior Management Team.						
CRITERION 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.	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; and						
	3. Policy and procedures are available to ensure patient centered care.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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; and						
	4. Implementation of performance improvement activities						
CRITERION 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.	1. Minutes are accessible, disseminated and acknowledged by the staff;						
	2. Attendance list of members with adequate representation of the service;						
	3. Frequency of meetings as scheduled; and						
	4. Discussion and resolutions are implemented.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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; and						
	f. verification of data on performance improvement activities, including performance indicators.						
CRITERION 9.1.1.10 (NEW)							
The Governing Body shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	1. Documented and approved BCP for unanticipated situations;						
	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment.						
	3. Clear actions and staff responsibilities during disruption;						
	4. Record of drills or tests, with follow-up actions, if conducted; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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	5. Review of Risk Register.						

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TOPIC 9.2
HUMAN RESOURCE DEVELOPMENT AND MAGEMENT

Standard 9.2.1
CREDENTIALING AND PRIVILEGING
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.

'Scope of practice' relates to the range and type of procedure(s) that a medical practitioner is permitted to perform within the available resources in the organisation.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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;	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/logbooks;						
	4. Recommendations from peer/referee;						
	5. Annual Practising Certificate (APC) which includes healthcare providers from hospital(s) under cluster initiative (where applicable);						
	6. Privileging certificates which include healthcare providers from hospital(s) under cluster initiative (where applicable);						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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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 staffs from hospital (s) under cluster initiative where applicable shall be privileged in the applicable hospital in their respective services.	7. Availability of the list of procedures requiring privileging; and						
	8. Availability of list of procedures to include core procedures specific to the disciplines performed by medical officers.						
CRITERION 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.	1. Formal letter of assignment or certificate of privileging with stipulated timeline are issued and reviewed accordingly; and						
	2. Updated list of staff with privileges conferred is made accessible at point of care.						
CRITERION 9.2.1.3 (CORE)							
Clinical staff performs within the privileges conferred.	1. Verification of procedures performed by individuals at point						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	of care within the awarded privileging rights with evidence of:						
	a. List of procedures privileged;						
	b. Operating list; and						
	c. Operating notes/clinical notes.						
CRITERION 9.2.1.4							
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 practice; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; and 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; and						
	4. The job description is acknowledged by the staff and signed by the Head of Service and dated.						

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Standard 9.2.2
STAFF TRAINING, EDUCATION, APPRAISAL AND RESEARCH

The Facility and all staff shall demonstrate an ongoing commitment to continuing medical education to ensure that all members of the workforce engage in continuous education and training to sustain required performance standards, while also being provided with opportunities to enhance and broaden their competencies.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. A Competency Development Framework checklist; and						
	2. The checklist should address the adequacy & appropriateness of staff education, training & experience.						
CRITERION 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.	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; and						
	4. Training module.						
CRITERION 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 including new digital technologies such as AI or disruptive innovations.	1. Staff involved in delivering of care are consulted prior to the implementation of AI systems along with its benefit and implication (e.g. minutes of meetings, townhall session, etc);						
	2. Training calendar include in-house/external courses/ workshop/conferences;						

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	3. Contents of training programme;						
	4. Training records on continuing education activities are kept and maintained for each staff including training in life support; and						
	5. Certificate of attendance/degree/post basic training.						
CRITERION 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.	1. Evidence of inclusion of results of audit activities, e.g. mortality and morbidity reviews, incident reporting, etc in educational activities; and						
	2. Evidence of improvement made from corrective or preventive measures from incident reports.						
CRITERION 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.	1. Performance appraisal for staff including medical practitioners is completed upon probationary period and as an annual exercise.						
CRITERION 9.2.2.6							
The Facility shall ensure that the staffs are trained in aspect of patient-centred care.	1. Documented evidence of training.						

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CRITERION 9.2.2.7							
Where appropriate the Facility shall endeavour to undertake clinical research using available resources.	1. Documented evidence of research activities, e.g. protocol, policies, consent, etc.						

Standard 9.2.3
STAFFING LEVEL AND STAFF COMPETENCY
The Head and staff of the Clinical Services including medical practitioners are individuals qualified by education, training and experience in accordance with their designated roles and applicable laws. The standards require organisations to implement structured processes that verify all appointed workforce members hold the appropriate qualifications, valid licences, or recognised professional scopes of practice, along with the requisite competence and training for their designated roles. Safeguards must be established to prevent individuals from operating beyond their authorised scope.

Furthermore, mechanisms shall be in place to routinely assess the continued competency and ongoing performance of all workforce members, in alignment with their job descriptions and defined scope of practice.

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CRITERION 9.2.3.1 (CORE)							
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	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.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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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; and 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.							
CRITERION 9.2.3.2 (CORE)							
The evaluation of continued competency and ongoing performance is systematically ensured through established processes. This may include regular reviews of scope of practice, structured competency	1. Reviews of scope of practice						
	2. Competency assessments, performance evaluations						

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assessments, formal performance evaluations, and verification of completed training necessary to maintain and enhance skills	3. Completion of required training to maintain skills (eg. Certificate)						

Standard 9.2.4
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.

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CRITERION 9.2.4.1							
There is a structured orientation programme for all newly appointed, contracted and outsourced staff to the Services including medical practitioners and for those new to specific areas that include but not limited to the following: <u>General</u> a) Vision and mission of the Facility; b) Organisation chart and reporting structure of the Facility; c) Environment and facility safety policies and procedures including sustainability practices; d) Infection control policies and procedures; e) Policies for performance management, patient safety	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 (q); and 3. Attendance list						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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(IPSG/MPSG) and risk management; f) Ethical practices and code of conduct including medicolegal awareness; g) Management of aggression, violence and harassment; and h) Patient and family rights <u>Services</u> a) Goals, objectives and organisational structure of clinical Services; b) Policies and procedures relevant to clinical Services; c) Working instructions for patient care; and d) Service continuity plan for clinical Services in response to internal and external disasters <u>Job-specific</u> a) Explanation of particular duties and functions; b) Explanation of the methods of assigning clinical care and the standards of clinical practice; c) Handover communication; d) Training in basic/advanced life support techniques; and e) Technology and equipment use including artificial intelligence, digital care and robotics.							

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Standard 9.2.5 (NEW)

The Clinical Services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the Clinical Services staff, ensuring a safe and healthy work environment.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9.2.5.1 (CORE)							
The Clinical Services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being. a) A health-promoting environment, e.g., stress management, burnout, staff engagement opportunities, workload monitoring, management of work life balance, healthy, lifestyle programmes e.g. Workplace Wellness Programs, Community-Based Health Initiatives; b) Staff shall be provided with appropriate supervision, support, and advice e.g., mentor mentee program; and c) There shall be clear procedures for the effective management of underperformance e.g., feedback on performance review or performance appraisal report.	1. The promotion of staff well-being may involve the following:						
	a. Evidence of a health promoting environment e.g., workplace wellness programme;						
	b. Evidence of proper supervision of staff; and						
	c. Evidence of staff appraisal programme with feedback on underperformance;						

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CRITERION 9.2.5.2 (CORE)							
The Clinical Services shall establish a safe mechanism for Clinical Services staff to express grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety.	1. Clinical Services staff suggestions and grievance reporting and processing mechanisms are available; and						
	2. The resolution of workplace issues may involve the following:						
	a. Measures and evidence of Clinical Services staff protection including whistleblowers against violence, bullying, and harassment e.g., awareness campaigns, anonymous reporting channel, Whistleblower policy; and						
	b. Documented policies and procedures for violence activation and Clinical Services staff protection.						
CRITERION 9.2.5.3 (NEW)							
A system shall be created to gather Clinical Services staff feedback about their workplace experience such as burnout, which shall be analysed and used to make improvements that enhance the work environment, Clinical Services staff satisfaction, and organisation culture.	1. Clinical Services staff feedback (e.g., minutes of sessions or Clinical Services staff satisfactions survey):						
	a. Evidence of action or improvement taken.						

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9.2.5.4 (NEW)							
The Clinical Services shall track sick leave and Clinical Services staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning	1. Evidence that workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments. The results shall be used to create focused actions that improve staff well-being, solve problems, and help retain employees.						

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TOPIC 9.3
POLICIES AND PROCEDURES

Standard 9.3.1
DEVELOPMENT, DERIVATION AND DOCUMENTATION
There are written and dated policies and procedures for all activities of the Clinical Services, including digital care. 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 in an environmentally sustainable healthcare and social care.

The facility also needs to develop policies and procedures and terms of reference to support the mental and physical wellbeing and professional development of their workforce and keep people safe at work.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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, current standard practices and Patients and Family Rights. 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.	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; and						
	4. The policies and procedures are endorsed and dated.						
CRITERION 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	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; and						

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with reference to relevant sources involved. Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.	3. Documented cross departmental policies						
CRITERION 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 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 (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	1. Documented policies and procedures that address but not limited to a) to (w);						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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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 business continuity 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) Provision of care in an environmentally sustainable healthcare and social care; p) Support the mental health and wellbeing of staffs; q) Professional development of staffs; r) Safety of people at work; s) Digital care; t) Management of clinical deterioration and escalation (e.g., NEWS2/MEWS protocol); u) Antimicrobial stewardship; v) Patient identification and procedure verification (time-out) for bedside procedures; and w) Assessment and management of frailty in elderly patients.							

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CRITERION 9.3.1.4 (CORE)							
Current policies and procedures are communicated to all staff.	1. Training and briefing on the current policies and procedures/Minutes of meetings; and						
	2. Circulation list and acknowledgement.						
CRITERION 9.3.1.5 (CORE)							
Policies and procedures are integrated in the care of Clinical Services patients incorporating but not limited to following pathways: a) Admission process; b) Pre procedure/investigation assessment; c) Peri procedure/investigation assessment; d) Intra procedure/ investigation protocols; e) Post procedure/investigation care; f) Referral to lead hospital/ tertiary centre; g) Prevention & control of infection; h) Day of surgery admission protocols; i) Environment of care for surgical patients; and j) Continuity of care. There is evidence of compliance with policies and procedures on various types of Clinical Services patients.	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.						

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CRITERION 9.3.1.6							
Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By- Laws and statutory requirements are accessible to staff.	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.						
CRITERION 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.	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; and						
	4. Evidence of patients/service users are informed of care delivered using AI systems.						

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TOPIC 9.4
FACILITIES AND EQUIPMENT

Standard 9.4.1
The Head of Clinical Services shall ensure adequate facilities and equipment that are safe, appropriate and environmentally sustainable are available for the staff to function effectively and to meet the goals and objectives of the Clinical Services.

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CRITERION 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.	1. Adequate and proper utilisation of space;						
	2. Appropriate type of equipment to match the complexity of services which include services under the cluster initiative where applicable;						
	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; and						
	5. Absence of overcrowding.						
CRITERION 9.4.1.2							
Existing facilities shall take cognisance of the safety of staff and patients.	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; and						
	3. Equipment should have scheduled planned preventive maintenance (PPM).						

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CRITERION 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.	1. Appropriate telecommunication modalities are available for daily operation and during emergencies.						
CRITERION 9.4.1.4 (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promotes environmentally sustainable care.						

Standard 9.4.2
FACILITIES AND EQUIPMENT FOR PATIENT CARE
Adequate facilities and equipment shall be available to provide safe and effective patient care, including digital care if any.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9.4.2.1							
Facilities are suitably located to facilitate easy access and to provide an atmosphere of user, environmental and 'disabled' friendly.	1. Floor plan indicates accessibility and patient and user friendly;						
	2. Feedback from patient satisfaction survey; and						
	3. Incident reporting relating to facilities if any.						
CRITERION 9.4.2.2 (CORE)							
Equipment, both for emergency and non-emergency usage, shall be appropriate to the level of care.	1. Availability of emergency and non-emergency equipment appropriate to level of care, such as defibrillator, emergency trolley (adults and children), suction machine,						

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	electrocardiogram (ECG) machine, infusion or syringe pump, vital sign monitor, etc.; and						
	2. Scheduled checking of items in emergency trolley.						
CRITERION 9.4.2.3 (CORE)							
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), The Energy Commission, Medical Device Authority (MDA), etc as evidence of compliance to the relevant standards and Acts; and						
	3. The equipment compliance with environmental regulations which include Environmental Quality Act 1974 (Act 127).						
CRITERION 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.	1. Planned Preventive Maintenance records, such as schedule, stickers, etc.;						
	2. Planned Replacement Programme where applicable;						
	3. Complaint records;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	4. Asset inventory; and						
	5. Disposal of asset according to policies and procedures and regulatory requirements.						
CRITERION 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	1. User training records						
	2. Planned Replacement Programme where applicable						
	3. Complaint records						
	4. Asset inventory						
CRITERION 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.	1. Equipment are being replaced and upgraded to meet current standard of care and advancement in technology in a planned and systematic manner.						
CRITERION 9.4.2.7							
Should any form of AI system is adopted for delivery of care, the management shall establish robust policies and procedures ensure that such systems are evaluated for their clinical relevance and technical feasibility. It should include stakeholder engagement, risk assessment (including cybersecurity and data privacy), staff training, and mechanisms	1. Documented process for the evaluation of digital care systems;						
	2. AI systems are managed in accordance with national legislation or regulations on the use of AI (eg from NAIO);						
	3. Availability of appropriate technical expertise to support the effective use and maintenance of digital care system;						
	4. Monitor and evaluate the use of AI systems to deliver care safely and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
for continuous monitoring, evaluation, and system optimization. Inclusive strategies must be in place to provide alternative modes of service delivery, ensure equitable access to care, and address digital literacy barriers. This may include in-person support, telephone-based services, and assistance in navigating digital platforms	mitigate any unintended consequences.; and						
	5. Measures are available to ensure use of digital care does not disadvantage patients/service users who lack access to digital devices or internet connectivity in order to use the provided digital services.						

Standard 9.4.3
FACILITIES FOR CLINICAL OUTPATIENT SERVICES
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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;	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;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and f) Adequate provision is made for patient comfort.	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; and					
	j.	Adequate waiting area, rest rooms, refreshments, reading material and parking space.					

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TOPIC 9.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

Standard 9.5.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9.5.1.1 (CORE)							
There are periodical 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-valuation for improvement; and g) Innovation	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; and						
	5. Records on innovation if available.						
CRITERION 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.	1. Minutes of meetings;						
	2. Letter of assignment of responsibilities; and						
	3. Job description.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. System for incident reporting is in place, which include:						
	a. Training of staff;						
	b. Policy on incident reporting;						
	c. Methodology of incident reporting; and						
	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; and						
	8. Feedback given to staff regarding incident reporting.						
CRITERION 9.5.1.4 (CORE)							
The staff including medical practitioners provide an appropriate peer group structure	1. Performance improvement activities;						
	2. Minutes of meetings; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and 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; and c) Clinical service to provide input periodically to the Governing Body on the safety and performance improvement activities."	3. Relevant reports and documents, e.g. clinical audit reports, incident reports, mortality and morbidity review reports, etc.						
CRITERION 9.5.1.5 (CORE)							
There is tracking and trending of specific performance indicators	1. Specific performance indicators monitored.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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 (mandatory indicator: a minimum of 30% of all mortalities and 30% of all morbidities discussed in a year). 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.	2. Records on tracking and trending analysis. 3. Minutes of mortality/morbidity audits meetings (mandatory evidence of compliance) 4. Remedial measures taken and followed through						
CRITERION 9.5.1.6							
Feedback on results of safety and performance improvement activities are regularly communicated to the staff to promote transparency, shared learning, and active engagement in improvement initiatives.	1. Results of safety and performance improvement activities are accessible to staff through education sessions, meetings and digital communications.						
CRITERION 9.5.1.7							
Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.	1. Documentation on performance improvement activities and performance indicator activities; and 2. Policy statement on anonymity on patients and providers involved in						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	performance improvement activities.						
CRITERION 9.5.1.8							
The organisation shall establish clear accountability arrangements for all care and treatment delivered with the support of AI systems. Care providers remain responsible for clinical decisions and outcomes, and must be aware that they may be held accountable if the use of AI contributes to patient or service user harm. Governance mechanisms shall include documentation of decision-making processes, delineation of human oversight roles, and regular review of AI system performance to ensure safe and ethical use.	1. Data privacy and patient data is used and kept by AI Systems;						
	2. Reviews and audits of clinical outputs and decision making; and						
	3. Incidents reporting.						

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TOPIC 9.6
SPECIAL REQUIREMENTS

Standard 9.6.1
CONTINUITY OF CARE
There shall be bi-directional line of care involving facilities of differing clinical response and/or under the cluster/networking initiative where appropriate level of care and optimum care to the patient is provided.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Documented policies and procedures are established to govern the arrangement of different categories of patient transfer;						
	2. Referral letter and supporting documents (which include imaging and laboratory results) 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; and						
	4. Ambulance transfer and in-transit records						

Standard 9.6.2
WHO GLOBAL SURGERY INITIATIVE
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9.6.2.1							
The Governing Body shall ensure that WHO Global Surgery	1. Departmental/Service operational policies that address (a) to (d);						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.	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; and						
	6. Proper and adequate equipment according to current standards.						

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SERVICE SUMMARY	
OVERALL RATING :	
OVERALL RISK :	

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SERVICE STANDARD 09A: CLINICAL SERVICES - MEDICAL RELATED SERVICES

PREAMBLE

Medical Related 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.

The Medical Related 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:

a) Appropriateness of clinical care;

b) Unwarranted variation in care that is not explained by the clinical circumstances or personal choices of the medical practitioners in:

i) Overuse of treatments or procedures that do not help patients get better;

ii) Underuse of care;

iii) Misuse (or errors) of doing something incorrectly and harming patients.

In addition to the above, the Medical Related Services also conduct teaching and training, research and audit activities where applicable.

TOPIC 9A.1
ORGANISATION AND MANAGEMENT

Standard 9A.1.1

The Medical Related 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 Related Services shall be easily accessible and continuity of care assured.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9A.1.1.1							
Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Medical Related Services are clearly documented and measurable, that indicates safety, quality and patient centered care. These reflect the roles and aspirations of the service and the	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 Related Services are measurable in line with the Facility statements available, endorsed and dated;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.	3. Evidence of planned reviews of the above statements (at least once in 3 years or in the event of any major changes);						
	4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc.); and						
	5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.						
CRITERION 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 Related Services, consultants, medical practitioners and staff of the Medical Related 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.	1. Clearly delineated current organisation chart specific to the Medical Related Services with line of functions and reporting relationships the Person In Charge (PIC), Head of Medical Related Services, relevant medical subspecialties services/units, consultants, medical practitioners and staff of the Medical Related Services;						
	2. Organisation chart of the service is endorsed, dated and accessible; and						
	3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).						
CRITERION 9A.1.1.3							
The Governing Body shall ensure that the Medical Related Services are organised in such a way as to:	1. Department/Service operational policies that address (a) to (d);						

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
a) Facilitate the provision of medical related 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.	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; and						
	6. Proper and adequate equipment according to current standards.						
CRITERION 9A.1.1.4							
There is a mechanism to ensure effective interaction between the Medical Related 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 Related Services delineating his/her authority, responsibilities and	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; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
accountabilities in a written document according to the relevant Acts to manage and control the Medical Related Services; and 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 Related Services.	3. Minutes of meetings of MDAC/Management.						
CRITERION 9A.1.1.5 (CORE)							
The Head of Medical Related 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.	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 Committee; and						
	3. Minutes of meeting of Senior Management Team.						
CRITERION 9A.1.1.6							
The assessment, planning, direction, evaluation and continuity of clinical care are the responsibility of medical practitioners managing individual	1. Medical Staff By-Laws; clause indicates clinical care responsibility of medical practitioners;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
patients, thus ensuring clinical independence.	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 as well as patient care plan including the results of diagnostic tests, 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; and						
	5. Evidence in clinical notes that the general management is as per current practise.						
CRITERION 9A.1.1.7							
The Head of Medical Related Services shall be involved for the following aspects of management of the services:	1. Evidence of (a) to (e) in the minutes of meetings of Medical Related Services indicate the involvement of Head of Service.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and e) Safety and performance improvement activities and risk management.	2. Endorsement of policies and procedures;						
	3. Request for allocation of budget and staffing; and						
	4. Implementation of performance improvement activities (refer to Quality Improvement activities).						
CRITERION 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 Related 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 representation of the service;						
	3. Frequency of meetings as scheduled; and						
	4. Discussion and resolutions are implemented.						
CRITERION 9A.1.1.9							
Where there are medical practitioners in training, there is evidence that:	1. Structured training programmes for medical practitioners are in place;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
a) Their responsibilities for patient care are documented; b) Their training needs are identified; and c) Appropriate supervision and training are given to the medical practitioners concerned.	2. Training timetable, continuing medical education and attendances list;						
	3. Assessment reports; and						
	4. Log books						
CRITERION 9A.1.1.10							
Appropriate statistics and records shall be maintained in relation to the provision of Medical Related Services and used for managing the services and patient care.	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; and						
	f. Data on performance improvement activities, including performance indicators.						
CRITERION 9A.1.1.11 (NEW)							
The Head of Services shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency	1. Documented and approved BCP for unanticipated situations;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment.						
	3. Clear actions and staff responsibilities during disruption;						
	4. Record of drills or tests, with follow-up actions, if conducted; and						
	5. Review of Risk Register.						

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TOPIC 9A.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

Standard 9A.2.1
CREDENTIALING AND PRIVILEGING
The Medical Related 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 Related Services.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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;	1. Documented policies and procedures are established to govern the credentialing and privileging processes which include items (a) to (h);						
	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;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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	6. Availability of list of procedures to include core procedures specific to the disciplines performed by medical officers; competency records/log books; and						
	7. Availability of list of procedures and its outcomes performed by each practitioner.						
CRITERION 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.	1. Formal letter of assignment or certificate of privileging with stipulated timeline are issued and reviewed accordingly; and						
	2. Updated list of staff with privileges conferred is made accessible at point of care.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9A.2.1.3							
Clinical staff performs within the privileges conferred.	1. Verification of procedures performed by individuals at point of care within the awarded privileging rights with evidence of:						
	a. List of procedures privileged; and						
	b. Clinical notes. The indication for the procedure clearly written.						
CRITERION 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; and	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; and						
	4. The job description is acknowledged by the staff and signed by the Head of Service and dated.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
vii) Administrative and clinical functions.							

Standard 9A.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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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; and						
	4. Certificate of attendance/degree/post basic training.						
CRITERION 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	1. Evidence of inclusion of results of audit activities, e.g. mortality and morbidity reviews, incident reporting, etc in educational activities; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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improvement studies and complaints, are taken into consideration when the content and structure of educational activities are planned.	2. Evidence of improvement made from corrective or preventive measures from incident reports.						
CRITERION 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.	1. Sufficient skilled trained staff to provide clinical supervision as per terms of Memorandum of Understanding.						
CRITERION 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.	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; and						
	4. Training module.						

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CRITERION 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.	1. 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.						
CRITERION 9A.2.2.6							
Where appropriate the Facility shall endeavour to undertake clinical research using available resources.	1. Documented evidence of research activities e.g. protocol, policies, consent etc.						

Standard 9A.2.3
STAFFING LEVEL AND STAFF COMPETENCY
The Head and staff of the Medical Related Services including medical practitioners are individuals qualified by education, training and experience commensurate with the requirements of the various positions and relevant laws.

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CRITERION 9A.2.3.1							
Deployment of all service providers for Medical in progress/is being updated/not updated 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	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;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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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.	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.						

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Standard 9A.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.

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CRITERION 9A.2.4.1							
There is a structured orientation programme for all newly appointed, contracted and outsourced staff to the Services that include but not limited to the following: <u>General</u> a) Vision and mission of the Facility. b) Organisation chart and reporting structure of the Facility. c) Environment and facility safety policies and procedures including sustainability practices d) Infection control policies and procedures. e) Policies for performance management, patient safety (IPSG/MPSG) and risk management. f) Ethical practices and code of conduct including medicolegal awareness. g) Management of aggression, violence and harassment. h) patient and family rights. <u>Services</u>	1. Policy requiring all new staff to attend a structured orientation programme;						
	2. There is Services orientation programme with relevant topics not limited to topics covered from (a) to (q); and						
	3. Attendance list.						

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i) Goals, objectives and organisational structure of Services. j) Policies and procedures relevant to Services k) Working instructions for patient care. l) Service continuity plan for Services in response to internal and external disasters. <u>Job-specific</u> m) Explanation of particular duties and functions. n) Explanation of the methods of assigning clinical care and the standards of clinical practice. o) Handover communication p) Training in basic/advanced life support techniques. q) Technology and equipment use including artificial intelligence, digital care and robotics.							

Standard 9A.2.5 (NEW)
The medical related services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the medical related staff, ensuring a safe and healthy work environment.

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				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9A.2.5.1 (CORE)						
The medical related services shall have policies and procedures for the promotion of	1. The promotion of staff well-being may involve the following:					

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staff physical, mental and spiritual well-being. a) A health-promoting environment, e.g., stress management, burn out, staff engagement opportunities, workload monitoring, management of work life balance, healthy, lifestyle programmes e.g. Workplace Wellness Programs, Community-Based Health Initiatives; b) Staff shall be provided with appropriate supervision, support, and advice e.g., mentor mentee program; and c) There shall be clear procedures for the effective management of underperformance e.g., feedback on performance review or performance appraisal report.	a. Evidence of a health promoting environment eg workplace wellness programme;						
	b. Evidence of proper supervision of staff; and						
	c. Evidence of staff appraisal programme with feedback on underperformance.						
CRITERION 9A.2.5.2 (CORE)							
The medical related services shall establish a safe mechanism for medical related staff to express grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with	1. Medical related staff suggestions and grievance reporting and processing mechanisms are available; and						
	2. The resolution of workplace issues may involve the following:						

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the principles of psychological safety.	a. Measures and evidence of medical related staff protection including whistleblowers against violence, bullying, and harassment e.g., awareness campaigns, anonymous reporting channel, Whistleblower policy; and						
	b. Documented policies and procedures for violence activation and medical related staff protection.						
CRITERION 9A.2.5.3 (NEW)							
A system shall be created to gather medical related staff feedback about their workplace experience such as burnout which shall be analysed and used to make improvements that enhance the work environment, medical related staff satisfaction, and organisation culture.	1. Staff feedback (e.g., minutes of sessions or staff satisfactions survey):						
	a. Evidence of action or improvement taken.						
CRITERION 9A.2.5.4 (NEW)							
The medical related services shall track sick leave and medical related staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning.	1. Evidence that workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments. The results shall be used to create focused actions that improve medical related staff well-being, solve problems, and help retain medical related employees.						

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TOPIC 9A.3
POLICIES AND PROCEDURES

Standard 9A.3.1
DEVELOPMENT, DERIVATION AND DOCUMENTATION
There are written and dated policies and procedures for all activities of the Medical Related 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.

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CRITERION 9A.3.1.1 (CORE)							
There are written policies and procedures for the Medical Related Services which are consistent with the overall policies of the Facility, regulatory requirements, current standard practices and Patients and Family Rights. 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.	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; and						
	4. The policies and procedures are endorsed and dated.						
CRITERION 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.	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; and						

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Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.	3. Documented cross departmental policies.						
CRITERION 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 Related Services; b) Clinical practice guidelines; c) Clinical documentation includes pain (or relevant presenting symptom / clinical alarm system) 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	1. Documented policies and procedures that address but not limited to (a) to (p).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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) Sustainability in healthcare programs; p) Digital care & ai programs (where applicable); q) Mental health support & workplace wellbeing programs; and r) Risk registry.							
CRITERION 9A.3.1.4							
Current policies and procedures are communicated to all staff.	1. Training and briefing on the current policies and procedures/ Minutes of meetings; and						
	2. Circulation list and acknowledgement.						
CRITERION 9A.3.1.5 (CORE)							
Policies and procedures are integrated in the care of patients	1. Compliance with policies and procedures through:						

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incorporating but not limited to following: a) Admission process b) Pre procedure/investigation assessment c) Intra procedure/ investigation protocols d) Post procedure/investigation care e) Transition of care process f) Prevention & control of infection g) Environment of care for patients h) Discharge process There is evidence of compliance with policies and procedures on various types of patients.	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; and						
	e. Review of patient grievances relating to policies & procedures.						
CRITERION 9A.3.1.6							
Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.	1. Copies of relevant policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.						
CRITERION 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.	1. Operational policy on 24-hour services;						
	2. Staffing level reflects good mix of experienced staff and the intensity of activities during each shift; and						

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	3. On-call roster is dated and authorised.						

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TOPIC 9A.4
FACILITIES AND EQUIPMENT

Standard 9A.4.1
The Head of Medical Related 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 Medical Related Services.

The Service shall practice responsible stewardship of these facilities and equipment to promote environmentally sustainable care.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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; and						
	6. Availability of areas to isolate patients who may aerosolize pathogens.						
CRITERION 9A.4.1.2							
Existing facilities shall take cognisance of the safety of staff and patients.	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;						

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	2. Adequate equipment and supplies for Medical Related Services, e.g. emergency trolley, functioning patient call bell, etc; and						
	3. Equipment should have scheduled planned preventive maintenance (PPM).						
CRITERION 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.	1. Appropriate telecommunication modalities are available for daily operation and during emergencies.						
CRITERION 9A.4.1.4 (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care.						

Standard 9A.4.2
FACILITIES AND EQUIPMENT FOR PATIENT CARE
Adequate facilities and equipment shall be available to provide safe and effective patient care.

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CRITERION 9A.4.2.1							
Facilities are suitably located to facilitate easy access and to provide an atmosphere of user,	1. Floor plan indicates accessibility and patient and user friendly;						

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environmental and 'disabled' friendly.	2. Feedback from patient satisfaction survey; and						
	3. Incident reporting relating to facilities if any.						
CRITERION 9A.4.2.2							
Equipment, both for emergency and non-emergency usage, shall be appropriate to the level of care	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; and						
	2. Scheduled checking of items in the emergency trolley.						
CRITERION 9A.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);						
	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; and						
	3. Incident reporting relating to facilities if any.						

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CRITERION 9A.4.2.4 (CORE)							
There is evidence that the facility implements a comprehensive maintenance program including predictive maintenance, planned preventive maintenance, and calibration managed by the head of department:	1. Planned preventive maintenance is carried out, and any identified issues are appropriately resolved;						
	2. A Planned Replacement Programme is in place to identify assets beyond their useful lifespan, with appropriate actions taken for repair, upgrade, or replacement;						
	3. Complaint records are maintained, with appropriate and timely actions taken to address them; and						
	4. Asset inventory includes a list of assets along with a plan for disposal or replacement of obsolete or beyond economic repair (BER) items, with actions documented and implemented.						
CRITERION 9A.4.2.5							
Where specialized equipment, including digital and AI technologies, is used, there is evidence that only trained and authorized staff operate it.	1. List of special equipment;						
	2. User training records;						
	3. Competency assessment record (include staff privileging);						
	4. Letter of authorisation; and						
	5. List of staff trained and authorised to operate specialised equipment.						
CRITERION 9A.4.2.6							
Equipment is periodically upgraded based on evidence to	1. Equipment are being replaced and upgraded to meet current standard						

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align with advances in operative and diagnostic techniques, with growing emphasis on integrating digital and AI technologies in health and care services	of care and advancement in technology in a planned and systematic manner						

Standard 9A.4.3
FACILITIES FOR MEDICAL 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.

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CRITERION 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.	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;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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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.	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; and						
	j. Adequate waiting area, rest rooms, refreshments, reading material and parking space.						
CRITERION 9A.4.3.2							
Adequate numbers of rooms are provided to ensure patient privacy and confidentiality for various patient care activities including: i) consultation (not more than one patient in a room at any time); j) conduct of minor procedures and nursing procedures; maintain a register of procedures performed; k) performance of various tests. l) Facilities may incorporate AI technologies to support patient privacy, such as through the implementation of virtual consultations or teleconferences within existing regulatory frameworks.	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; and						
	d. List of procedures done.						

TOPIC 9A.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

Standard 9A.5.1
The Head of Services shall foster high quality performance by involving staff in safety and continuous improvement initiatives, including systematic risk management, active staff involvement and the use of performance data to drive service enhancements. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

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CRITERION 9A.5.1.1							
There are periodical 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; and f) Re-evaluation for improvement and g) Innovation	1. Planned performance improvement activities include (a) to (g);						
	2. Records, trending and analysis on performance improvement studies and activities;						
	3. Minutes of performance improvement meetings;						
	4. Mortality and morbidity audits with remedial actions;						
	5. Records of performance improvement and remedial actions adoption into training needs, policy, guidelines and standard operating procedures; and						
	6. Records on innovation, if available.						
CRITERION 9A.5.1.2							
The Head of Services has assigned the responsibilities for	1. Minutes of meetings discussing progress on improvement activities.						

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planning, monitoring and managing safety and performance improvement activities to appropriate individuals/personnel within the respective services.	2. Letter of assignment of responsibilities.						
	3. Job description.						
CRITERION 9A.5.1.3							
The Head of Services shall ensure that staff are trained and that they complete incident reports. These reports shall be promptly reported, investigated, and discussed by the staff with learning objectives, before being submitted to the PIC of the Facility. Where appropriate, according to the Facility matrix, reported incidents undergo an RCA, and corrective and preventive action is taken within the agreed time frame to prevent recurrence.	1. A system for incident reporting is in place and includes the following:						
	a. Training of staff;						
	b. Policy on incident reporting; and						
	c. Register/Records of incidents.						
	2. Completed incident reports:						
	a. RCA;						
	b. Corrective and preventive action plans; and						
	c. Remedial measure.						
	3. Clinical audit including patient safety reviews (e.g., mortality and morbidity review, etc.);						
	4. Sentinel Event Investigations with appropriate corrective and preventive actions (CAPA), and oversight by the governing body;						

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	5. Grievance Mechanism, both staff and public, including grievance reporting and processing mechanisms are available;						
	6. Minutes of Meetings;						
	7. Acknowledgment by Head of Services and PIC; and						
	8. Feedback and learnings from incident reporting are shared with staff.						
CRITERION 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. 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	1. Performance improvement activities;						
	2. Minutes of Meetings; and						
	3. Relevant reports and documents, e.g. clinical audit reports, incident reports, mortality and morbidity review reports, etc.						

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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.							
CRITERION 9A.5.1.5							
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 (*suggest to make morbidity/ mortality meeting*	1. Specific performance indicators monitored;						
	2. Minutes of mortality/morbidity audits meetings;						
	3. Records on tracking and trending analysis. to recommend tracking and trending to be done for at least the last 3 years; and						

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as compulsory and to choose other 2 from the list). b) Percentage of unplanned re-admission for the same complain within 72 hours of discharge percentage of readmission, suggest to follow KKM HPIA of readmission within 48h (Target <0.5%); 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; 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; and h) For subspecialities unit in medical related services shall monitor any other 2 indicators. Subspecialties units in the Medical Related Services	4. Remedial measures taken where appropriate						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Subspecialties units in the Medical Related Services, e.g. Respiratory Medicine, Gastroenterology, Nephrology, Rheumatology, etc shall monitor any other two (2) indicators to support its goals and objectives. There must be tracking and trending to be done for at least the last 3 years of specific performance indicators, including: i) The number of mortality and morbidity (M&M) audits or meetings conducted within the department; and or not limited to but at least two (2) of the following: j) Percentage of readmission, suggest to follow KKM HPIA of readmission within 48h (target <0.5%); k) Dengue Case Fatality Rate (Target: 0%); l) 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); m) Number of deaths occurring within 24 hrs of admission; n) Percentage of Identification of causative pathogen for community acquired pneumonia;							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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o) Number of healthcare worker infected with tuberculosis (or any other infectious diseases), the source of which is likely hospital-related; p) Subspecialties performance indicator if applicables, e.g. Respiratory Medicine, Gastroenterology, Nephrology, Rheumatology, etc shall monitor any other two (2) indicators to support its goals and objectives.							
CRITERION 9A.5.1.6 (NEW)							
The Services participates in the Facility's safety culture assessment. The results are utilized by Service leadership to inform and guide efforts to improve the culture of safety within the Service.	1. Safety Culture Survey for staff						
CRITERION 9A.5.1.7							
Feedback on the results of safety and performance improvement activities is regularly communicated to the staff to promote transparency, shared learning, and active engagement in improvement initiatives.	1. Results of safety and performance improvement activities are accessible to staff through education sessions, meetings and digital communications.						
CRITERION 9A.5.1.8							
Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical	1. Documentation on performance improvement activities and performance indicators.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
practitioners, staff and patients is preserved.							

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SERVICE SUMMARY	
OVERALL RATING:	
OVERALL RISK:	

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SERVICE STANDARD 09B: CLINICAL SERVICES - SURGICAL RELATED SERVICES

PREAMBLE

Surgical Related 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.

The Surgical Related 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:

a) Appropriateness of clinical care;

b) Unwarranted variation in care that is not explained by the clinical circumstances or personal choices of the medical practitioners in:

- ***i) Overuse of treatments or procedures that do not help patients get better;***
- ***ii) Underuse of care;***
- ***iii) Misuse (or errors) of doing something incorrectly and harming patients.***

In addition to the above, the Surgical Related Services also conduct teaching and training, research and audit activities where applicable.

TOPIC 9B.1
ORGANISATION AND MANAGEMENT

Standard 9B.1.1

The Surgical Related 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 Related Services shall be easily accessible and continuity of care assured.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9B.1.1.1							
Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Surgical Related Services are clearly documented and measurable, that indicates safety, quality and patient centered care. These reflect the roles and aspirations of the service and the	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 are measurable in line with the Facility statements available, endorsed and dated;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.	3. Evidence of planned reviews of the above statements (at least once in 3 years or in the event of any major changes);						
	4. List of Specialty Services Provided;						
	5. These statements are communicated to all staff (orientation programme, minutes of meeting, etc.); and						
	6. Achievement of goals and objectives are monitored, reviewed and revised accordingly.						
CRITERION 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 Related Services, consultants, medical practitioners and staff of the Surgical Related 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.	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head of Surgical Related Services, relevant surgical subspecialties services/units, consultants, medical practitioners and staff of the Surgical Related Services;						
	2. The organisation chart of the service is endorsed, dated and accessible; and						
	3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9B.1.1.3							
The Governing Body shall ensure that the Surgical Related Services are organised in such a way as to: a) Facilitate the provision of surgical related 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.	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; and						
	6. Proper and adequate equipment according to current standards.						
CRITERION 9B.1.1.4							
There is a mechanism to ensure effective interaction between the Surgical Related 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:	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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
a) The appointment of a medical practitioner as the Head of Surgical Related 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 Related Services.	3. Minutes of meetings of MDAC/Management.						
CRITERION 9B.1.1.5 (CORE)							
The Head of Surgical Related Services has: a) Representation of the Service in committees and subcommittees where relevant; b) Representation of the Service in clinical staff liaison meetings; and c) Involvement and provide regular input to the Senior Management Team.	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; and						
	3. Minutes of meeting of Senior Management Team.						
CRITERION 9B.1.1.6							
The assessment, planning, direction, evaluation and continuity of clinical care are the responsibility of medical	1. Medical Staff By-Laws; clause indicate clinical care responsibility of medical practitioners; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
practitioners managing individual patients, thus ensuring clinical independence.	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, as well as patient care plan including the results of diagnostic tests, valid name stamp of medical practitioner.						
CRITERION 9B.1.1.7							
The Head of Surgical Related 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; including physical and mental wellbeing; c) Development of policies and procedures and ensuring compliance to them; d) Facility and equipment management; and e) Safety and performance improvement activities and risk management.	1. Evidence of (a) to (e) in the minutes of meetings of Surgical Related Services indicate the involvement of Head of Service;						
	2. Endorsement of policies and procedures;						
	3. Request for allocation of budget and staffing; and						
	4. Implementation of performance improvement activities.						
CRITERION 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 Related Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible,	1. Minutes are accessible, disseminated and acknowledged by the staff;						
	2. Attendance list of members with adequate representation of the service;						
	3. Frequency of meetings as scheduled; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
communicated to all staff of the service and implemented.	4. Discussion and resolutions are implemented.						
CRITERION 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; and c) Appropriate supervision and training are given to the medical practitioners concerned.	1. Structured training programmes for medical practitioners are in place;						
	2. Training timetable, continuing medical education and attendances list;						
	3. Assessment reports; and						
	4. Logbooks.						
CRITERION 9B.1.1.10							
Appropriate statistics and records shall be maintained in relation to the provision of Surgical Related Services and used for managing the services and patient care.	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; and						
	f. Data on performance improvement activities, including performance indicators.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9B.1.1.11 (NEW)							
The Head of Services shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	1. Documented and approved BCP for unanticipated situations;						
	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment.						
	3. Clear actions and staff responsibilities during disruption;						
	4. Record of drills or tests, with follow-up actions, if conducted; and						
	5. Review of Risk Register.						

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TOPIC 9B.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

Standard 9B.2.1
CREDENTIALING AND PRIVILEGING
The Surgical Related 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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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;	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, privileging and re-privileging;						
	3. Annual Practising Certificate (APC), National Specialist Register (NSR) certificates and privileging certificates;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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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.	4. Recommendations from peer/referee;						
	5. Availability of the list of specialised procedures requiring credentialing and privileging; and						
	6. Availability of list of specialised 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.						
CRITERION 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.	1. Formal letter of assignment or certificate of privileging with stipulated timeline are issued and reviewed accordingly; and						
	2. Updated list of staff with privileges conferred is made accessible at point of care.						
CRITERION 9B.2.1.3 (CORE)							
Clinical staff performs within the privileges conferred.	1. Policy and procedure for verification of privileged procedures at the point of care;						

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	2. 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; and					
		c. Operating notes/clinical notes.					
CRITERION 9B.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;	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						
	3. Relevant privileges granted where applicable;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
iii) General and specific accountabilities; iv) Qualifications required and privileges granted; v) Staffing patterns; vi) Statutory Regulations. e) Administrative and clinical functions.	4. The job description is acknowledged by the staff and signed by the Head of Service and dated.						

Standard 9B.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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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CRITERION 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.	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; and						
	4. Certificate of attendance/degree/post basic training.						
CRITERION 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	1. Evidence of inclusion of results of audit activities, e.g. mortality and morbidity reviews, incident reporting, etc in educational activities; and						

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improvement studies and complaints, are taken into consideration when the content and structure of educational activities are planned.	2. Evidence of improvement made from corrective or preventive measures from incident reports.						
CRITERION 9B.2.2.3							
In a Facility where undergraduate and post graduate 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.	1. Sufficient skilled trained staff to provide clinical supervision as per terms of Memorandum of Understanding;						
	2. Letter of Appointment from Academic Institution; and						
	3. Certification as a trainer or educator.						
CRITERION 9B.2.2.4 (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.	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; and						
	4. Training module.						
CRITERION 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.	1. Performance appraisal for staff including medical practitioner is completed upon probationary period and as an annual exercise.						

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CRITERION 9B.2.2.6							
Where appropriate the Facility shall endeavour to undertake clinical research using available resources.	1. Documented evidence of research activities e.g. protocol, policies, consent and outcomes, etc.						

Standard 9B.2.3
STAFFING LEVEL AND STAFF COMPETENCY
The Head and staff of the Surgical Related Services including medical practitioners are individuals qualified by education, training and experience commensurate with the requirements of the various positions and relevant laws.

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CRITERION 9B.2.3.1							
Deployment of all service providers for Surgical Related 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	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; and						
	e. Monitoring sick leave and resignation.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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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; and 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.							

Standard 9B.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.

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CRITERION 9B.2.4.1							
There is a structured orientation programme for all newly appointed, contracted and outsourced staff to the Surgical Related Services including	1. Policy requiring all new staff to attend a structured orientation programme;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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medical practitioners and for those new to specific areas that include but not limited to the following: <u>General</u> a) Vision and mission of the Facility b) Organisation chart and reporting structure of the Facility c) Environment and facility safety policies and procedures including sustainability practices d) Infection control policies and procedures e) Policies for performance management, patient safety (IPSG/MPSG) and risk management f) Ethical practices and code of conduct including medicolegal awareness g) Management of aggression, violence and harassment h) Patient and family rights <u>Services</u> i) Goals, objectives and organisational structure of Surgical Related Services j) Policies and procedures relevant to Surgical Related Services k) Working instructions for patient care l) Service continuity plan for Surgical Related Services in	2. There is a Surgical Services orientation programme with relevant topics not limited to topics covered from (a) to (q); and						
	3. Attendance list.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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response to internal and external disasters Job-specific m) Explanation of particular duties and functions n) Explanation of the methods of assigning clinical care and the standards of clinical practice o) Handover communication p) Training in basic/advanced life support techniques q) Technology and equipment use including artificial intelligence, digital care and robotics							

Standard 9B.2.5 (NEW)
The Surgical Related Services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the medical related staff, ensuring a safe and healthy work environment.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9B.2.5.1 (CORE)							
The surgical related services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being. a) A health-promoting environment, e.g., stress management, burn out, staff engagement opportunities,	1. The promotion of staff well-being may involve the following:						
	a. Evidence of a health promoting environment eg workplace wellness programme;						
	b. Evidence of proper supervision of staff; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
workload monitoring, management of work life balance, healthy, lifestyle programmes e.g. Workplace Wellness Programs, Community-Based Health Initiatives; b) Staff shall be provided with appropriate supervision, support, and advice e.g., mentor mentee program; and c) There shall be clear procedures for the effective management of underperformance e.g., feedback on performance review or performance appraisal report.	c. Evidence of staff appraisal programme with feedback on underperformance.						
CRITERION 9B.2.5.2 (CORE)							
The surgical related services shall establish a safe mechanism for surgical related staff to express grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety.	1. Surgical staff suggestions and grievance reporting and processing mechanisms are available;						
	2. The resolution of workplace issues may involve the following:						
	a. Measures and evidence of surgical related staff protection including whistleblowers against violence, bullying, and harassment e.g., awareness campaigns, anonymous reporting channel, Whistleblower policy; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	b. Documented policies and procedures for violence activation and surgical related staff protection.						
CRITERION 9B.2.5.3 (NEW)							
A system shall be created to gather surgical related staff feedback about their workplace experience such as burnout which shall be analysed and used to make improvements that enhance the work environment, surgical related staff satisfaction, and organisation culture.	1. Surgical related staff feedback (e.g., minutes of sessions or medical related staff satisfactions survey):						
	a. Evidence of action or improvement taken.						
CRITERION 9B.2.5.4 (NEW)							
The surgical related services shall track sick leave and medical related staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning	1. Evidence that workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments. The results shall be used to create focused actions that improve surgical related staff well-being, solve problems, and help retain surgical related employees.						

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TOPIC 9B.3
POLICIES AND PROCEDURES

Standard 9B.3.1
DEVELOPMENT, DERIVATION AND DOCUMENTATION
There are written and dated policies and procedures for all activities of the Surgical Related 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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9B.3.1.1 (CORE)							
There are written policies and procedures for the Surgical Related Services which are consistent with the overall policies of the Facility, regulatory requirements, current standard practices and Patients and Family Rights. 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.	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; and						
	4. The policies and procedures are endorsed and dated.						
CRITERION 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.	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; and						

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Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.	3. Documented cross departmental policies.						
CRITERION 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 Related Services; b) Clinical practice guidelines; c) Clinical documentation includes pain (or relevant presenting symptom / clinical alarm system) 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	1. Documented policies and procedures that address but not limited to (a) to (y).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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) Safe use of lasers and other radiation devices; p) Sedation policy and procedures; q) 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 r) Management of implantable device including recall; s) Management of loan equipment; t) Recognition of and respond to clinical deterioration (AEWS for adult & paeds); u) Restrain and seclusion; v) Prevention of catheter and tubing misconnections;							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
w) Managing critical clinical alarms; x) Booking surgical procedures according to granted clinical privileges; y) Environmentally sustainable practices including action plans to optimise resource consumption							
CRITERION 9B.3.1.4							
Current policies and procedures are communicated to all staff.	1. Training and briefing on the current policies and procedures/ Minutes of meetings; and						
	2. Circulation list and acknowledgement.						
CRITERION 9B.3.1.5 (CORE)							
Policies and procedures are integrated in the care of surgical patients incorporating but not limited to following pathways: a) Admission process b) Preoperative assessment c) Intraoperative protocols d) Post-anaesthesia care e) Transition of care process f) Surgical site infection prevention g) Day of surgery admission protocols h) Environment of care for surgical patients i) Discharge process There is evidence of compliance with policies and procedures on various types of surgical patients.	3. 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.					

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9B.3.1.6							
Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.	1. Copies of relevant policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.						
CRITERION 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.	1. Operational policy on 24-hour services;						
	2. Staffing level reflects good mix of experienced staff and the intensity of activities during each shift; and						
	3. On-call roster is dated and authorised.						

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TOPIC 9B.4
FACILITIES AND EQUIPMENT

Standard 9B.4.1
The Head of Surgical Related 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 Surgical Services.

The Service shall practice responsible stewardship of these facilities and equipment to promote environmentally sustainable care.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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	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; and						
	5. Absence of overcrowding.						
CRITERION 9B.4.1.2							
Existing facilities shall take cognisance of the safety of staff and patients. Environmentally sustainable practices adopted for quality of care.	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;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	3. Equipment should have scheduled planned preventive maintenance (PPM); and						
	4. Adoption of green infrastructure and practices.						
CRITERION 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.	1. Appropriate telecommunication modalities available for daily operation and during emergencies.						
CRITERION 9B.4.1.4 (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care.						

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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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9B.4.2.1							
Facilities are suitably located to facilitate easy access and to provide an atmosphere of user, environmental and 'disabled' friendly.	1. Floor plan indicates accessibility and patient and user friendly;						
	2. Feedback from patient satisfaction survey; and						
	3. Incident reporting relating to facilities if any.						
CRITERION 9B.4.2.2							
Equipment, both for emergency and non-emergency usage, shall be appropriate to the level of care	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;						
	3. Disinfection procedure/protocol of equipment (endoscopes, forceps, ear tips etc); and						
	1. Dedicated area for dirty and clean procedures.						
CRITERION 9B.4.2.3							
There is documented evidence that equipment complies with	1. Testing, commissioning and calibration records (certificates or stickers); and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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relevant national/international standards and current statutory requirements.	2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), Medical Device Authority (MDA) etc as evidence of compliance to the relevant standards and Acts.						
CRITERION 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.	1. Planned Preventive Maintenance records such as schedule, stickers, etc;						
	2. Planned Replacement Programme where applicable;						
	3. Complaint records and documented response by service provider; and						
	4. Asset inventory.						
CRITERION 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.	1. User training records;						
	2. Competency assessment record;						
	3. Letter of authorisation; and						
	4. List of staff trained and authorised to operate specialised equipment.						
CRITERION 9B.4.2.6							
Equipment is upgraded (based on evidence) from time to time so as to keep pace with advancement in operative and	1. Equipment are being replaced and upgraded to meet current standard of care and advancement in technology in a planned and systematic manner.						

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diagnostic techniques and technology.							

Standard 9B.4.3
FACILITIES FOR SURGICAL 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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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;	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;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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a) Adequate provision is made for patient comfort	h. Floor plan indicates accessibility to supporting services and optimisation of space;						
	i. Adequate patient personal use items, e.g. Wheelchair, etc; and						
	j. Adequate waiting area, rest rooms, refreshments, reading material and parking space.						
CRITERION 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.	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; and						
	d. List of procedures done.						

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TOPIC 9B.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

Standard 9B.5.1.
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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CRITERION 9B.5.1.1 (CORE)							
There are periodical 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 g) Innovation	1. Planned performance improvement activities include (b) 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; and						
	6. Records on innovation if available.						
CRITERION 9B.5.1.2							
The Head of Surgical Services has assigned the responsibilities for planning, monitoring and safety and performance	1. Minutes of meetings;						
	2. Letter of assignment of responsibilities; and						

DISTRIBUTION

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improvement activities to appropriate individual / personnel within the respective services.	1. Job description.						
CRITERION 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.	1. A system for incident reporting is in place, which includes:						
	a. Training of staff;						
	b. Policy on incident reporting;						
	c. Methodology of incident reporting; and						
	d. Register/records of incidents.						
	2. Completed incident reports;						
	3. RCA;						
	4. Corrective and preventive action plans;						
	5. Remedial measure;						
	6. Minutes of meetings;						
	7. Acknowledgment by Head of Service and PIC/Hospital Director;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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	8. Feedback given to staff regarding incident reporting; and						
	9. Counselling and follow up of staff who are second victims of adverse or sentinel events.						
CRITERION 9B.5.1.4 (CORE)							
There is tracking and trending of specific performance indicators. Please refer to the manual. 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.	1. Performance improvement activities;						
	2. Minutes of Meetings; and						
	3. Relevant reports and documents, e.g. clinical audit reports, incident reports, mortality and morbidity review reports, etc.						

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.							
RITERION 9B.5.1.5							
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 elective surgical inpatients who had principal procedure conducted on day of admission. Subspecialties units in the Surgical Services shall monitor	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; and						
	5. Compliance Audits on Remedial Measures.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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any other two (2) indicators to support its goals and objectives. <u>Breast and Endocrine surgery</u> e) Recurrent laryngeal nerve injury in primary benign thyroid surgery. (Target: ≤3%) f) Percentage of patients with clear surgical margins in Breast Conserving Surgery (BCS). (Target: ≥85%) g) Percentage of breast cancer with discussion at a multidisciplinary meeting. (Target: ≥90%) <u>Bariatric Surgery</u> h) Percentage of Patient Complications within 30 days from Gastric Bypass Bariatric surgery i) Percentage of Patient Complications within 30 days from Sleeve Gastrectomy Bariatric Surgery j) Percentage of Patient Complications within 30 days from Adjustable Gastric Banding Bariatric surgery <u>Trauma Surgery</u> k) Turnaround time from booking OT for crash laparotomy to surgery within less than 60minutes. (Target: ≥95%)							

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l) Percentage of trauma laparotomy cases performed without complication. (Target: ≥95%) <u>Cardiothoracic Surgery</u> m) Elective isolated Coronary Artery Bypass Grafting (CABG) surgery mortality rate. (Target: ≤3%) in high volume centres or (Target: ≤7%) in low volume centre. n) Incidence rate of Pneumothorax following removal of chest drains. (Target: ≤5%) <u>Colorectal Surgery</u> o) Percentage of patients with unclear surgical margins in Rectal Cancer surgery. (Target: ≤10%) p) Post-operative mortality rate for all major elective colorectal surgery. (Target: ≤10%) <u>Hepatobiliary surgery</u> q) Rate of common bile duct injury in laparoscopic cholecystectomy should be less than 0.5% r) Percentage of post hepatectomy liver failure Grade B and above s) A contrast-enhanced pancreas protocol computed tomographic (CT) or							

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magnetic resonance (MR) scan within four weeks of surgery t) Conversion rate from laparoscopic to open cholecystectomy <u>Neurosurgery</u> u) Time of intervention less than 200 minutes for trauma craniotomy/craniectomy from time of admission to the operating theatre in neurosurgical centres. (Target: ≥95%) v) Percentage of patients with surgical site infection following clean elective craniotomy. (Target: ≤5%) w) Percentage of patients with hydrocephalus require a second shunt operation within 30days of the first shunt surgery. x) Percentage of infection in primary shunt insertion (positive CSF culture) within 30 days of insertion. <u>Plastic Surgery</u> y) Percentage of Full Thickness Skin Graft (FTSG) with ≥80% graft take following elective surgery. (Target: ≥90%) z) Percentage of post-palatoplasty haemorrhage patients reintubated and/or							

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returned to operating theatre within (≤) 24 hours of primary palate repair. (Target: ≤5%) <u>Robotic Surgery</u> a.Rate of emergency undocking <u>Upper GI Surgery</u> aa) Percentage of patients with clear surgical margin post resection of Gastric Tumour performed with curative intent (Target: ≥ 90%) bb) Incidence rate of oesophageal anastomotic leak requiring surgical intervention (Target: ≤ 10%) cc) Percentage of patients with Gastric Adenocarcinoma who underwent curative surgical resection (RO) where ≥ 15 lymph nodes are resected and pathologically examined (Target: ≥ 90%) <u>Urology</u> dd) Percentage of ureters that were stone free following ureterorenoscopy (URS) lithotripsy (Target: ≥ 90%) ee) Percentage of safe percutaneous nephrolithotripsy (PCNL) (Target: ≥ 80%) ff) Percentage of safe transurethral resection of the							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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prostate (TURP) (Target: ≥ 90%) <u>Vascular surgery</u> gg) Post-operative mortality rate for open repair of Abdominal Aortic Aneurysm (AAA) (Target: ≤ 5%) hh) Percentage of access-related hand ischemia (ARHI) following native arterio-venous fistula (AVF) creation (Target: ≤ 0.05%) <u>Orthopaedic Surgery</u> ii) Percentage of patients with waiting time of less than (≤) 75 minutes to see doctor in Orthopaedic Outpatient Clinic after completion of pre-planned procedure (Target ≥ 90%) jj) Percentage of patients with surgical site infection following clean elective orthopaedic surgery (Target ≤ 1%) kk) Percentage of unacceptable internal fixations of fracture requiring revision (Target ≤ 1%) ll) Percentage of post primary total knee replacement patient with length of stay in hospital of ≤ 5 working days (Target ≥ 80%) mm) Post-operative sepsis rate in Orthopaedic (Target ≤2%)							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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<u>Ophthalmology</u> nn) Percentage of patients developed infectious endophthalmitis following cataract surgery oo) Percentage of patients without pre-existing ocular co-morbidity obtained visual acuity of 6/12 or better within (<) 3 months following cataract surgery <u>Otorhinolaryngology Surgery</u> There is tracking and trending of specific performance indicators not limited to but at least two (2) of the following: pp) number of mortality/morbidity audits/meetings being conducted in the department with documentation of cases discussed qq) percentage of unplanned re-admission within 72 hours of discharge rr) unplanned return to operating theatre within the same hospital admission following surgery ss) ≥ 90% of patients with waiting time of ≤ 90 minutes to see the doctor at Otorhinolaryngology (ORL) Clinic tt) Improvement of hearing following myringoplasty ≥ 70%							

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uu) Incidence of primary post tonsillectomy hemorrhage ≤ 3% vv) Specialty specific indicators in centere providing such services e.g. Cochlear implant, Sleep laboratory, Head & Neck oncology							
CRITERION 9B.5.1.6 (NEW)							
The Services participates in the Facility's safety culture assessment. The results are utilized by Service leadership to inform and guide efforts to improve the culture of safety within the Service.	1. Safety Culture Survey for staff						
CRITERION 9B.5.1.7							
Feedback on results of safety and performance improvement activities are regularly communicated to the staff to promote transparency, shared learning, and active engagement in improvement initiatives.	1. Results on safety and performance improvement activities are accessible to staff through education sessions, meetings and digital communications.						
CRITERION 9B.5.1.8							
Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.	1. Documentation on performance improvement activities and performance indicators.						
	2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						

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SERVICE SUMMARY	
OVERALL RATING :	
OVERALL RISK :	

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SERVICE STANDARD 09C: CLINICAL SERVICES – OBSTETRICS AND GYNAECOLOGY SERVICES

PREAMBLE

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:

Appropriateness of clinical care;

a) Unwarranted variation in care that is not explained by the clinical circumstances or personal choices of the patient or medical practitioners in:

b) Overuse of treatments or procedures that do not help patients get better;

- ***i) Underuse of care;***
- ***ii) Misuse (or errors) of doing something incorrectly and harming patients.***
- ***iii) Inadequate explanation/counselling of the patient***

In addition to the above, The Obstetrics and Gynaecology Services also conduct teaching and training, research and audit activities where applicable.

TOPIC 9C.1
ORGANISATION AND MANAGEMENT

Standard 9C.1.1

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.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9C.1.1.1							
Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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Obstetrics and Gynaecology Services 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.	2. Goals and objectives of the Obstetrics and Gynaecology Services are measurable in line with the Facility statements available, endorsed and dated;						
	3. Evidence of planned reviews of the above statements (at least once in 3 years or in the event of any major changes);						
	4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc); and						
	5. Achievement of goals and objectives are monitored, reviewed and revised with appropriate action plans implemented accordingly.						
CRITERION 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	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~~,~~ relevant subspecialties services/units, consultants, medical practitioners and staff of the Obstetrics and Gynaecology Services;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.	2. The organisation chart of the service is endorsed, dated and accessible; and						
	3. The organisation chart is revised when there is a major change in any of the items (c)(i) to (iv).						
CRITERION 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 caring and holistic manner with due regard for the needs, dignity and privacy of	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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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patients and confidentiality of their personal information; b) Assure continuity of care; c) Address the professional needs and wellbeing of the staff; 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	4. Involvement of Head of the Service in the Medical and Dental Advisory Committee/Medical Advisory Committee and ward meetings;						
	5. Minutes of meetings; and						
	6. Proper and adequate equipment according to current standards.						
CRITERION 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:	1. Letter of appointment/assignment and delineation of duties and responsibilities of the Head of the Service;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; a) 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*.	2. Letter of appointment and Terms of Reference as member of the Medical and Dental Advisory Committee/Medical Advisory Committee; and						
	3. Minutes of meetings of MDAC/Management.						
CRITERION 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;	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;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
c) Involvement and provide regular input to the Senior Management Team.	2. Minutes of meetings of committees; and						
	3. Minutes of meeting of Senior Management Team.						
CRITERION 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.	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, as well as patient care plan including the results of diagnostic tests, valid name stamp of medical practitioner.						
CRITERION 9C.1.1.7							
The Head of Obstetrics and Gynaecology Services shall be involved	1. Evidence of (a) to (e) in the minutes of meetings of Obstetrics and Gynaecology Services indicate the involvement of Head of Service;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.	2. Endorsement of policies and procedures;						
	3. Request for allocation of budget and staffing; and						
	4. Implementation of performance improvement activities.						
CRITERION 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 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.	1. Minutes are accessible, disseminated and acknowledged by the staff;						
	2. Attendance list of members with adequate representation of the service;						
	3. Frequency of meetings as scheduled; and						
	4. Discussion and resolutions are implemented.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Structured training programmes for medical practitioners are in place;						
	2. Training timetable, continuing medical education and attendances list;						
	3. Assessment reports; and						
	4. Logbooks.						
CRITERION 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.	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;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	2. 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 confer the current privileges; and						
	3. Data on safety and performance improvement activities including performance indicators.						
CRITERION 9C.1.1.11							
The Head of Services shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	1. Documented and approved BCP for unanticipated situations;						
	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment.						
	3. Clear actions and staff responsibilities during disruption;						
	4. Record of drills or tests, with follow-up actions, if conducted; and						
	5. Review of Risk Register.						

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TOPIC 9C.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

Standard 9C.2.1
CREDENTIALING AND PRIVILEGING
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9C.2.1.1 (CORE)							
There is documented evidence of appropriate training and competency for the granting of clinical privileging and re-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	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;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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 timeframe 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.	4. Recommendations from peer/referee;						
	5. Availability of the list of specialised procedures requiring credentialing and privileging/re-privileging; and						
	6. Availability of list of specialised procedures specific to the disciplines performed by medical officers; competency records/logbooks if applicable.						
CRITERION 9C.2.1.2 (CORE)							
Documented evidence of privileges conferred by the Governing Body is available and	1. Formal letter of assignment or certificate of privileging with stipulated timeline are issued and reviewed accordingly; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
accessible to relevant staff at point of care.	2. Updated list of staff with privileges conferred is made accessible.						
CRITERION 9C.2.1.3							
Clinical staff performs within the privileges conferred.	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; and						
	c. Operating notes/clinical notes.						
CRITERION 9C.2.1.4							
There are written and dated specific job descriptions for all categories of staff that include:	2. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e);						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.	3. Job description includes specialisation skills;						
	4. Relevant privileges granted where applicable; and						
	5. The job description is acknowledged by the staff and signed by the Head of Service and dated.						

Standard 9C.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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9C.2.2.1							
There are continuing education activities for staff including	1. Training calendar includes in-house/external courses/ workshop/conferences;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
medical practitioners to pursue professional interests and to prepare for current and future changes in practice.	2. Contents of training programme;						
	3. Training records on continuing education activities are kept and maintained for each staff including training in life support; and						
	4. Certificate of attendance/degree/post basic training.						
CRITERION 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.	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.						
CRITERION 9C.2.2.3							
In a Facility where undergraduate and post graduate 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.	1. Sufficient skilled trained staff to provide clinical supervision as per terms of Memorandum of Understanding.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9C.2.2.4							
There is evidence of training needs assessment and staff development plans which provide the knowledge and skills required for staff to maintain competency in their current positions and future advancement.	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; and						
	4. Training module.						
CRITERION 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.	1. Performance appraisal for staff including medical practitioners is completed upon probationary period and as an annual exercise.						
CRITERION 9C.2.2.6							
Where appropriate the Facility shall endeavour to undertake clinical research using available resources.	1. Documented evidence of research activities e.g. protocol, policies, consent and outcomes, etc.						

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Standard 9C.2.3
STAFFING LEVEL AND STAFF COMPETENCY
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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. Management (recovery) plan during disaster; and f. Mitigations measures to manage instances of insufficient trained staff affecting compliance with the regulatory requirement					

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.							

Standard 9C.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.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9C.2.4.1 (NEW)							
There is a structured orientation programme for all newly appointed, contracted and outsourced staff to the Services that include but not limited to the following: <u>General</u>	1. Policy requiring all new staff to attend a structured orientation programme;						
	2. There is Services orientation programme with relevant topics not limited to topics covered from (a) to (q); and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
a) Vision and mission of the Facility b) Organisation chart and reporting structure of the Facility c) Environment and facility safety policies and procedures including sustainability practices d) Infection control policies and procedures e) Policies for performance management, patient safety (IPSG/MPSG) and risk management f) Ethical practices and code of conduct including medicolegal awareness g) Management of aggression, violence and harassment h) Patient and family rights Services i) Goals, objectives and organisational structure of Services j) Policies and procedures relevant to Services k) Working instructions for patient care l) Service continuity plan for Services in response to internal and external disasters Job-specific	3. Attendance list.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
m) Explanation of particular duties and functions n) Explanation of the methods of assigning clinical care and the standards of clinical practice o) Handover communication p) Training in basic/advanced life support techniques q) Technology and equipment use including artificial intelligence, digital care and robotics							

Standard 9C.2.5 (NEW)

The Obstetrics and Gynaecology Services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the Obstetrics and Gynaecology staff, ensuring a safe and healthy work environment.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9C.2.5.1 (CORE)							
The Obstetrics and Gynaecology Services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being. a) A health-promoting environment, e.g., stress	1. The promotion of staff well-being may involve the following:						
		a. Evidence of a health promoting environment eg workplace wellness programme;					

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
management, burn out, staff engagement opportunities, workload monitoring, management of work life balance, healthy, lifestyle programmes e.g. Workplace Wellness Programs, Community-Based Health Initiatives; b) Staff shall be provided with appropriate supervision, support, and advice e.g., mentor mentee program; and c) There shall be clear procedures for the effective management of underperformance e.g., feedback on performance review or performance appraisal report.	b. Evidence of proper supervision of staff; and						
	c. Evidence of staff appraisal programme with feedback on underperformance.						
CRITERION 9C.2.5.2 (CORE)							
The Obstetrics and Gynaecology Services shall establish a safe mechanism for Obstetrics and Gynaecology staff to express grievances, provide suggestions and report risk concerns or safety	1. Obstetrics and Gynaecology staff suggestions and grievance reporting and processing mechanisms are available;						
	2. The resolution of workplace issues may involve the following:						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety.	a. Measures and evidence of Obstetrics and Gynaecology staff protection including whistleblowers against violence, bullying, and harassment e.g., awareness campaigns, anonymous reporting channel, Whistleblower policy; and						
	b. Documented policies and procedures for violence activation and Obstetrics and Gynaecology staff protection.						
CRITERION 9C.2.5.3 (NEW)							
A system shall be created to gather staff feedback about their workplace experience such as burnout which shall be analysed and used to make improvements that enhance the work environment, staff satisfaction, and organisation culture.	1. Staff feedback (e.g., minutes of sessions or staff satisfactions survey):						
	a. Evidence of action or improvement taken.						
CRITERION 9C.2.5.4 (NEW)							
The Obstetrics and Gynaecology Services shall track sick leave and medical related staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning	1. Evidence that workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments. The results shall be used to create focused actions that improve Obstetrics and Gynaecology staff well-being, solve						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	problems, and help retain Obstetrics and Gynaecology employees.						

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TOPIC 9C.3
POLICIES AND PROCEDURES

Standard 9C.3.1
DEVELOPMENT, DERIVATION AND DOCUMENTATION
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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, current standard practices and Patients and Family Rights. 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.	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; and						
	4. The policies and procedures are endorsed and dated.						
CRITERION 9C.3.1.2							
Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, Management and	1. Minutes of committee meetings on development and revision on policies and procedures;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
where required with other external service providers and with reference to relevant sources involved. Cross departmental collaboration is practised to ensure integrated care is implemented in the development of relevant policies and procedures where applicable.	2. Minutes of meeting with evidence of cross reference with other departments; and						
	3. Documented cross departmental policies.						
CRITERION 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) Scope of services provided by Obstetrics and Gynaecology Services c) Clinical practice guidelines; d) Clinical documentation includes pain as the 5th vital sign where appropriate; e) Care transition and handover communication; f) drug prescription, dispensing and administration; g) Blood transfusion;	1. Documented policies and procedures that address but not limited to (a) to (q).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
h) Continuing of care including regular review of patient, review of investigation results, discharge (planned or At Own Risk), referrals and escort as necessary; i) Pain management; j) Management of patients under police custody/prisoner; k) Management of cases with an infectious disease including notification of notifiable diseases; l) The responsibilities of the staff including medical practitioners in relation to internal and external disasters are documented, and known to the staff (contingency plan); m) Incident reports shall be compiled, investigated, discussed and recorded and action plans implemented; n) End of life care; o) Management of a death; p) Referral and transfer intra- and interfacility; and q) Health promotion activities							
CRITERION 9C.3.1.4							
Current policies and procedures are communicated to all staff.	1. Training and briefing on the current policies and procedures/ Minutes of meetings; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	2. Circulation list and acknowledgement.						
CRITERION 9C.3.1.5 (CORE)							
Policies and procedures are integrated in the care of patients incorporating but not limited to following: a) Admission process b) Preoperative assessment c) Intraoperative protocols d) Post-anaesthesia care e) Transition of care process f) Surgical site infection prevention g) Day of surgery admission protocols h) Environment of care for surgical patients i) Discharge process There is evidence of compliance with policies and procedures on various types of patients.	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.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9C.3.1.6							
Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.	1. Copies of relevant policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.						
CRITERION 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.	1. Operational policy on 24-hour services;						
	2. Staffing level reflects good mix of experienced staff and the intensity of activities during each shift; and						
	3. On-call roster is dated and authorised.						
CRITERION 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	1. Policies that address (a) to (c);						
	2. Documented evidence of compliance:						
		a. Patient's medical record;					
		b. Fetal monitoring records.					

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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 cantered care) care where indicated. c) Very high risk patients shall be managed in the ICU/HDU (preferably obstetric ICU/HDU).							
CRITERION 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.	1. Policy on issuance of antenatal and postnatal records						
	2. Antenatal and postnatal patient records						
	3. Observation for compliance with policy						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9C.3.1.10							
The Obstetrics and Gynaecology Services shall ensure that postnatal mothers being discharged will continue to receive postnatal care.	Policy on postnatal care that indicates mothers are appropriately referred to continue to receive postnatal home visits.						

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TOPIC 9C.4
FACILITIES AND EQUIPMENT

Standard 9C.4.1
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 Obstetrics and Gynaecology Services.

The Service shall practice responsible stewardship of these facilities and equipment to promote environmentally sustainable care.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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	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; and						
	6. Patient confidentiality must be preserved.						
CRITERION 9C.4.1.2							
Existing facilities shall take cognisance of the safety of staff and patients.	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;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Environmentally sustainable practices adopted for quality of care.	2. Adequate equipment and supplies for Obstetrics and Gynaecology Services, e.g. emergency trolley, functioning patient call bell, etc; and						
	3. Equipment should have scheduled planned preventive maintenance (PPM).						
CRITERION 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.	1. Appropriate telecommunication modalities available for daily operation and during emergencies.						
CRITERION 9C.4.1.4 (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promotes environmentally sustainable care.						

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Standard 9C.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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9C.4.2.1							
Facilities are suitably located to facilitate easy access and to provide an atmosphere of user, environmental and 'disabled' friendly.	1. Floor plan indicates accessibility and patient and user friendly;						
	2. Feedback from patient satisfaction survey; and						
	3. Incident reporting relating to facilities if any.						
CRITERION 9C.4.2.2							
Equipment, both for emergency and non-emergency usage, shall be appropriate to the level of care.	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; and						
	2. Scheduled checking of items in emergency trolley.						
CRITERION 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); and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), Medical Device Authority (MDA) etc as evidence of compliance to the relevant standards and Acts.						
CRITERION 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.	1. Planned Preventive Maintenance records such as schedule, stickers, etc;						
	2. Planned Replacement Programme where applicable;						
	3. Complaint records and documented response by service provider; and						
	4. Asset inventory.						
CRITERION 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.	1. User training records;						
	2. Competency assessment record;						
	3. Letter of authorisation; and						
	4. List of staff trained and authorised to operate specialised equipment.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Equipment are being replaced and upgraded to meet current standard of care and advancement in technology in a planned and systematic manner; and						
	2. Equipment replacement and upgrade to follow green procurement practices.						

Standard 9C.4.3
FACILITIES FOR OBSTETRICS AND GYNAECOLOGY 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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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;	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;						

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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	c. safe keeping of medical records; and						
	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.						
	k. Baby friendly facilities						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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); b) Conduct of minor procedures and nursing procedures; maintain a register of procedures performed; c) Performance of various tests.	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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TOPIC 9C.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

Standard 9C.5.1.
The Head of Obstetrics and Gynaecology Services shall ensure a consistent provision of quality and safe care by fostering a culture of continuous safety and performance improvement activities among the sfaff of the Obstetrics and Gynaecology Services.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9C.5.1.1							
There are periodical planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Obstetrics and Gynaecology Services. The Service may consider the content of the WHO Global Patient Safety Action Plan to inform their approach on safety goals. a) Define quality and safety goals; b) Planned activities; c) Data collection; d) Monitoring and evaluation of the performance; e) Implementation of action plan; f) Action plan for improvement; g) Re-evaluation for improvement; and h) Innovation.	1. Safety goals are defined and documented;						
	2. Planned performance improvement activities include (a) to (h);						
	3. Records on performance improvement activities;						
	4. Minutes of performance improvement meetings;						
	5. Performance improvement studies;						
	6. Mortality and morbidity audits with remedial actions; and						
	7. Records on innovation if available.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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CRITERION 9C.5.1.2							
The Head of Obstetrics and Gynaecology Services assigns the responsibility for planning, monitoring and managing safety and performance improvement activities to designated individual / personnel within the services.	1. Minutes of Meetings;						
	2. Letter of assignment of responsibilities; and						
	3. Job description.						
CRITERION 9C.5.1.3							
The Head of Labour and Delivery Services shall ensure that the staff are trained in incident reporting. All safety incidents, including near misses, are timely reported, investigated with lessons learned shared with staff and completed report forwarded to the Person In Charge (PIC) of the Facility. Safety incidents reported are systematically analysed using appropriate methodology such as Root Cause Analysis and action taken within the agreed time frame to prevent recurrence.	1. System for incident reporting is in place, which includes:						
		a. Training of staff;					
		b. Policy on safety incident reporting;					
		c. Methodology of safety incident reporting; and					
		d. Register/records of safety incidents.					
	2. Completed incident reports:						
		a. Investigative analysis (e.g Root Cause Analysis (RCA);					
		b. Corrective and preventive action plans; and					

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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	c. Remedial measure.						
	3. Minutes of Meetings;						
	4. Acknowledgment by Head of Service and PIC/Hospital Director; and						
	5. Feedback/lessons learned are shared with staff regarding incident reporting.						
CRITERION 9C.5.1.4 (CORE)							
The Obstetrics and Gynecology Services has Clinical (Obstetrics) Risk Management Programme that proactively identifies, assesses, and manages risks within its scope of operations that may affect patient or staff safety. Risk mitigation action steps are taken in response to the identified risks. a) The medical practitioners undertake clinical reviews of all risk assessments, incident reports, audits and safety and performance improvement activities:	1. Risk Management Programme;						
	2. Updated unit-level risk register;						
	3. Record of risk management/mitigation action plans;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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i) In multidisciplinary committees within the service; and ii) 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. There is a regular review of the Risk Management Programme in the Obstetrics and Gynaecology Services with an updated risk registry and progress of risk mitigation actions.	4. Risk Management Programme updates and progress (e.g., minutes of meetings, mitigation tracking logs);						
	5. Risk reports submission to relevant Facility's oversight committee; and						
	6. Relevant reports and documents, e.g. clinical audit reports, incident reports, mortality and morbidity review reports, etc.						
CRITERION 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) Facility with specialists: i) Emergency and Elective Caesarean Rates	1. Specific performance indicators monitored and validated;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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(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) District Facility without specialists: Maternity Services 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%) There is also tracking and trending of not limited to but at least one (1) outcome data to monitor how care, treatment, or other services provided improve the health status and wellbeing of patients. Examples of outcomes data are clinical results or	2. Selected outcomes data monitored and validated;						
	3. Records on tracking and trending analysis;						
	4. Minutes of mortality/morbidity audits meetings;						
	5. Remedial measures taken where appropriate; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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patient-related outcome measures (PROMs). These indicators or outcomes are selected based on identified areas requiring improvement which is reviewed regularly for continued relevance. New indicators or outcomes may be selected to address current or emerging patient safety priorities.	6. Records (e.g., meeting minutes) showing regular review of indicators performance or outcomes data results.						
CRITERION 9C.5.1.6 (NEW)							
The Services participates in the Facility's safety culture assessment. The results are utilized by Service leadership to inform and guide efforts to improve the culture of safety within the Service.	1. Safety Culture Survey for staff						
CRITERION 9C.5.1.7							
Feedback on the results of safety and performance improvement activities is regularly communicated to the staff to promote transparency, shared learning, and active engagement in improvement initiatives.	1. Results of safety and performance improvement activities are accessible to staff through education sessions, meetings and digital communications.						

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CRITERION 9C.5.1.8							
Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved. Safety and performance improvement activities are appropriately documented and kept, with safeguards in place to preserve the confidentiality of patients and staff involved.	1. Policy statement on ensuring the confidentiality and anonymity of patients and staff involved in safety and performance improvement activities.						
	2. Evidence of anonymised data used in reports or discussions related to safety and performance improvement activities.						

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SERVICE SUMMARY	
OVERALL RATING :	
OVERALL RISK :	

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SERVICE STANDARD 09D: CLINICAL SERVICES - PAEDIATRIC SERVICES

PREAMBLE

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:

a) Appropriateness of clinical care;

b) Unwarranted variation in care that is not explained by the clinical circumstances or personal choices of the medical practitioners in:

- ***i) Overuse of treatments or procedures that do not help patients get better;***
- ***ii) Underuse of care;***
- ***iii) Misuse (or errors) of doing something incorrectly and harming patients.***

In addition to the above, the Paediatric Services also conduct teaching and training, research and audit activities where applicable.

TOPIC 9D.1
ORGANISATION AND MANAGEMENT

Standard 9D.1.1

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.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

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CRITERION 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 centered care. These reflect the roles and aspirations of the service and the needs of the community. These	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 are measurable in line with the Facility statements available, endorsed and dated;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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statements are monitored, reviewed and revised as required accordingly and communicated to all staff.	3. Evidence of planned reviews of the above statements (at least once in 3 years or in the event of any major changes);						
	4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc); and						
	5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.						
CRITERION 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; 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, relevant paediatric subspecialties services/units, consultants, medical practitioners and staff of the Paediatric Services;						
	2. Organisation chart of the service is endorsed, dated and accessible; and						
	3. The organisation chart is revised every 3 years or when there is a major change in any of the items (c)(i) to (iv).						
CRITERION 9D.1.1.3							
The Governing Body shall ensure that the Paediatric Services are organised in such a way as to:	1. Department/Service operational policies that address (a) to (d);						

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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.	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; and						
	6. Proper and adequate equipment according to current standards.						
CRITERION 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	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; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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 to clinical governance, i.e. in planning, coordinating, implementation, control and to improve activities relating to Paediatric Services.	3. Minutes of meetings of MDAC/Management.						
CRITERION 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; and c) Involvement and provide regular input to the Senior Management Team. The head of the paediatrics services and the relevant head of the paediatric subspecialty has representation in the relevant committee and subcommittee	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; and						
	3. Minutes of meeting of Senior Management Team.						
CRITERION 9D.1.1.6							
The assessment, planning, direction, evaluation and continuity of clinical care are the responsibility of medical	1. Medical Staff By-Laws; clause indicate clinical care responsibility of medical practitioners; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
practitioners managing individual patients, thus ensuring clinical independence.	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.						
CRITERION 9D.1.1.7							
The Head of Paediatric Services shall be involved for the following aspects of management of the services: d) The preparation of budget and ensuring that expenditure remains within the budget allocated; e) Human resource management and development; including physical and mental wellbeing; f) Development of policies and procedures and ensuring compliance to them; g) Facility and equipment management; and h) Safety and performance improvement activities and risk management.	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; and						
	4. Implementation of performance improvement activities e.g. Critical Incidences Meeting.						
CRITERION 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,	1. Minutes are accessible, disseminated and acknowledged by the staff;						
	2. Attendance list of members with adequate representation of the service;						
	3. Frequency of meetings as scheduled; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
communicated to all staff of the service and implemented.	4. Discussion and resolutions are implemented.						
CRITERION 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; and c) Appropriate supervision and training are given to the medical practitioners concerned.	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; and						
	4. Job responsibilities of the medical practitioners in training, e.g. Job Description (JD), Orientation Manual.						
CRITERION 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.	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; and						
	f. Data on performance improvement activities, including performance indicators.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9D.1.1.11 (NEW)							
The Head of Services shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	1. Documented and approved BCP for unanticipated situations;						
	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment.						
	3. Clear actions and staff responsibilities during disruption;						
	4. Record of drills or tests, with follow-up actions, if conducted; and						
	5. Review of Risk Register.						

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TOPIC 9D.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

Standard 9D.2.1
CREDENTIALING AND PRIVILEGING
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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	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 and re-privileging;						
	3. Annual Practising Certificate (APC), National Specialist Register (NSR) certificate and privileging certificate;						
	4. Recommendations from peer/referee;						
	5. Availability of the list of specialised procedures requiring credentialing and privileging; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and g) The recommendations of the relevant department and/or major professional services for privileges to be granted are taken into consideration.	6. Availability of list of specialised 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.						
CRITERION 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.	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; and						
	3. Verification of procedures performed by individuals at point of care within the awarded privileging						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	rights with evidence of list of procedures privileged.						
CRITERION 9D.2.1.3 (CORE)							
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; and 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; and						
	4. The job description is acknowledged by the staff and signed by the Head of Service and dated.						

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Standard 9D.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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Training calendar includes in-house/external courses/ workshop/conferences;						
	2. Training on patient-centered care (i.e: Patient and Family Rights), communication skills (i.e: 10S) ;						
	3. Contents of training programme;						
	4. Training records on continuing education activities are kept and maintained for each staff; and						
	5. Certificate of attendance/degree/post basic training.						
CRITERION 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.	1. Evidence of inclusion of results of audit activities, e.g. mortality and morbidity reviews, incident reporting, etc in educational activities; and						
	2. Evidence of improvement made from corrective or preventive measures from incident reports.						

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CRITERION 9D.2.2.3							
In a Facility where undergraduate and post graduate 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.	1. Sufficient skilled trained staff to provide clinical supervision as per terms of Memorandum of Understanding; and						
	2. For Nursing training program, there will be 1 Clinical Instructor to 15 students.						
CRITERION 9D.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.	1. Training needs assessment is carried out and gaps identified eg list of core training modules/ lectures attended eg. Neonatal Resucitation Programme (NRP), Infection Control & Malaysian Paediatric Life Support (MPLS);						
	2. A staff development plan based on training needs assessment is available;						
	3. Training schedule/calendar is in place; and						
	4. Training module.						
CRITERION 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.	1. Performance appraisal for staff including medical practitioners is completed upon probationary period/ clinical posting or as an annual exercise, e.g. Case Based Discussion (CBD), Clinical						

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	Examination (CEX) and annual appraisal.						
CRITERION 9D.2.2.6							
Where appropriate the Facility shall endeavour to undertake clinical research using available resources.	1. Documented evidence of research activities e.g. protocol, policies, consent and outcomes, etc.						

Standard 9D.2.3
STAFFING LEVEL AND STAFF COMPETENCY

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.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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	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; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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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; and 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.	d. Duty roster						

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Standard 9D.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.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9D.2.4.1							
There is a structured orientation programme for all newly appointed, contracted and outsourced staff to the Services that include but not limited to the following: <u>General</u> a) Vision and mission of the Facility b) Organisation chart and reporting structure of the Facility c) Environment and facility safety policies and procedures including sustainability practices d) Infection control policies and procedures e) Policies for performance management, patient safety (IPSG/MPSG) and risk management f) Ethical practices and code of conduct including medicolegal awareness g) Management of aggression, violence and harassment h) Patient and family rights <u>Services</u> i) Goals, objectives and organisational structure of Paediatric Services	1. Policy requiring all new staff to attend a structured orientation programme;						
	2. There is a Paediatric Services orientation programme with relevant topics not limited to topics covered from (a) to (q); and						
	3. Attendance list						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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j) Policies and procedures relevant to Paediatric Services k) working instructions for patient care l) Service continuity plan for Paediatric Services in response to internal and external disasters <u>Job-specific</u> m) Explanation of particular duties and functions n) Explanation of the methods of assigning clinical care and the standards of clinical practice o) Handover communication p) Training in basic/advanced life support techniques q) Technology and equipment use including artificial intelligence, digital care and robotics.							

Standard 9D.2.5 (NEW)
The Paediatric Services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the medical related staff, ensuring a safe and healthy work environment.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9D.2.5.1 (CORE)						
The Paediatric Services shall have policies and procedures for	1. The promotion of staff well-being may involve the following:					

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the promotion of staff physical, mental and spiritual well-being. a) A health-promoting environment, e.g., stress management, burnout, staff engagement opportunities, workload monitoring, management of work life balance, healthy, lifestyle programmes e.g. Workplace Wellness Programs, Community-Based Health Initiatives; b) staff shall be provided with appropriate supervision, support, and advice e.g., mentor mentee program; and c) There shall be clear procedures for the effective management of underperformance e.g., feedback on performance review or performance appraisal report.	a. Evidence of a health promoting environment, e.g. workplace wellness programme; b. Evidence of proper supervision of staff; and c. Evidence of staff appraisal programme with feedback on underperformance.						
CRITERION 9D.2.5.2 (CORE)							
The Paediatric Services shall establish a safe mechanism for staff to express grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of	1. Paediatric staff suggestions and grievance reporting and processing mechanisms are available; and 2. The resolution of workplace issues may involve the following:						

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non-retaliation in accordance with the principles of psychological safety.	a. Measures and evidence of paediatric staff protection including whistleblowers against violence, bullying, and harassment e.g., awareness campaigns, anonymous reporting channel, Whistleblower policy; and						
	b. Documented policies and procedures for violence activation and paediatric staff protection.						
CRITERION 9D.2.5.3 (NEW)							
A system shall be created to gather paediatric staff feedback such as burnout about their workplace experience which shall be analysed and used to make improvements that enhance the work environment, paediatric staff satisfaction, and organisation culture.	1. Paediatric staff feedback (e.g., minutes of sessions or medical related staff satisfactions survey):						
	a. Evidence of action or improvement taken.						
CRITERION 9D.2.5.4 (NEW)							
The Paediatric Services shall track sick leave and paediatric staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning	1. Evidence that workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments. The results shall be used to create focused actions that improve paediatric staff well-being, solve problems, and help retain paediatric employees.						

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TOPIC 9D.3
POLICIES AND PROCEDURES

Standard 9D.3.1
DEVELOPMENT, DERIVATION AND DOCUMENTATION

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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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, current standard practices and Patients and Family Rights. 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.	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; and						
	4. The policies and procedures are endorsed and dated.						
CRITERION 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.	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						

DISTRIBUTION

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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 5th 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 (Refer Paediatric Services Operational Policy 2024); e) Transition to adult care services (16-18 years old); f) Handover communication; g) Drug prescription, dispensing and administration; h) Blood transfusion; i) Continuing of care including regular review of patient, review of investigation results, referrals and escort as necessary; j) Management of cases with an infectious disease including notification of notifiable diseases; k) The responsibilities of the staff including medical	1. Documented policies and procedures that address but not limited to (a) to (q).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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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) Risk management/patient safety and security; n) End of life care; and o) Management of a death							
CRITERION 9D.3.1.4							
Current policies and procedures are communicated to all staff.	1. Training and briefing on the current policies and procedures/ Minutes of meetings; and						
	2. Circulation list and acknowledgement.						
CRITERION 9D.3.1.5 (CORE)							
Policies and procedures are integrated in the care of patients incorporating but not limited to following: a) Admission process; b) Preoperative assessment; c) Intraoperative protocols; d) Post-anaesthesia care; e) Transition of care process f) Surgical site infection prevention; g) Day of surgery admission protocols; h) Environment of care for surgical patients; and i) Discharge process	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; and						
	d. Practices in line with established policies and procedures.						

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There is evidence of compliance with policies and procedures on various types of patients.							
CRITERION 9D.3.1.6							
Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.	1. Copies of relevant policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.						
CRITERION 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.	1. Operational policy on 24-hour services;						
	1. Staffing level reflects good mix of experienced staff and the intensity of activities during each shift; and						
	2. On-call roster is dated and authorised.						

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TOPIC 9D.4
FACILITIES AND EQUIPMENT

Standard 9D.4.1
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 Services.

The Service shall practice responsible stewardship of these facilities and equipment to promote environmentally sustainable care.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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	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. Overnight facilities for carers accompanying child during admission;						
	5. Easy access and clear exit routes; and						
	6. Absence of overcrowding.						
CRITERION 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, and	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;						

DISTRIBUTION

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
a) WHO Standards for improving the quality of care for children and young adolescents	3. Equipment should have scheduled planned preventive maintenance (PPM); and						
	4. Toilet facilities are adequate, user and disabled friendly, e.g. a. Grab- bar and nurse call system for disabled-friendly b. Clear opening with patient's toilet door ≥0.9 m and must not swing inward or into corridor						
CRITERION 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.	1. Appropriate telecommunication modalities are available for daily operation and during emergencies; and						
	2. Medical Alert Systems, e.g. Code Blue System.						
CRITERION 9D.4.1.4 (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care.						

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Standard 9D.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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9D.4.2.1							
Facilities are suitable to facilitate easy access and to provide an atmosphere of user, environmental and 'disabled' friendly.	1. Floor plan indicates accessibility and patient and user friendly;						
	2. Feedback from patient satisfaction survey; and						
	3. Incident reporting relating to facilities if any.						
CRITERION 9D.4.2.2							
Equipment, both for emergency and non-emergency usage, shall be appropriate to the level of care and of varying sizes, including monitoring devices.	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.; and						
	2. Scheduled checking of items in emergency trolley.						
CRITERION 9D.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); and						
	2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), Medical Device Authority (MDA) etc as evidence of compliance to the relevant standards and Acts.						

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CRITERION 9D.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.	1. Planned Preventive Maintenance records such as schedule, stickers, etc;						
	2. Planned Replacement Programme where applicable;						
	3. Complaint records and documented response by service provider; and						
	4. Asset inventory.						
CRITERION 9D.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.	1. User training records.						
	2. Competency assessment record.						
	3. Letter of authorisation. and						
	4. List of staff trained and authorised to operate specialised equipment.						
CRITERION 9D.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.	1. Equipment are being replaced and upgraded to meet current standard of care and advancement in technology in a planned and systematic manner.						

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CRITERION 9D.4.2.7 (CORE)							
A Special Care Nursery may be located within a paediatric 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;	2. Where Special Care Nursery is established the unit includes features as stated in (a) to (f).						

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e) Disposable areas for diaper and soil linen. f) Emergency equipment such as pulse oximeter, oxygen blender, positive pressure ventilation device/ T-piece resuscitator and transport incubator							

Standard 9D.4.3
FACILITIES FOR PAEDIATRIC 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.

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CRITERION 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	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;					

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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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) Facilities for the disabled	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; and						
	j. Adequate waiting area, rest rooms, reading material						
CRITERION 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); and b) Conduct of minor procedures and nursing procedures; maintain a register of procedures performed.	1. Adequate facilities for consultation and patient care activities that address (a) to (b) 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; and						
	d. List of procedures done.						

TOPIC 9D.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

Standard 9D.5.1.
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 Services.

The Head of Paediatric Services shall ensure compliance to monitoring of specific performance indicators.

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CRITERION 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; and g) Innovation.	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; and						
	6. Records on innovation if available.						
CRITERION 9D.5.1.2							
The Head of Paediatric Services has assigned the responsibilities for planning, monitoring and safety and performance improvement activities to	1. Minutes of Meetings;						
	2. Letter of assignment of responsibilities; and						

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appropriate individual / personnel within the respective services	3. Job description.						
CRITERION 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.	1. System for performance activities is in place, which includes:						
	a. Training of staff;						
	b. Policy on performance activity						
	c. Methodology; and						
	d. Register/records of incidents.						
	2. Corrective and preventive action plans;						
	3. Remedial measure;						
	4. Minutes of Meetings;						
	5. Acknowledgment by Head of Service and PIC/Hospital Director; and						
	6. Feedback given to staff regarding incident reporting / shortfalls.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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; and 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) For paediatric inpatients, identification tag with the patient's name and registration number shall be affixed to the patient's limb.	1. Performance improvement activities; 2. Minutes of Meetings; and 3. Relevant reports and documents, e.g. clinical audit reports, incident reports, mortality and morbidity review reports, etc.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Reference: a) Paediatric Services Operational Policy 2024 b) *Garis panduan Sistem Kawalan Keselamatan Bayi Di Hospital-Hospital KKM Edisi Kedua)*							
CRITERION 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 paediatric patients with unplanned readmission to paediatric ward within (≤) 48 hours of discharge (Target: ≤ 0.5%) c) Community acquired pneumonia death rate (Target:≤ 0.5%) d) Percentage of survival of all livebirths with birthweight between 1000 – 1499g (Target: ≥ 85%) **Refer:** Technical Specifications Clinical Services Quality Indicators (CLISQI) Medical Programme 2025	1. Specific performance indicators monitored;						
	2. Records on tracking and trending analysis;						
	3. Reports of mortality/morbidity audits meetings; and						
	4. Remedial measures taken where appropriate.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9D.5.1.6 (NEW)							
The Services participates in the Facility's safety culture assessment. The results are utilized by Service leadership to inform and guide efforts to improve the culture of safety within the Service.	1. Safety Culture Survey for staff						
CRITERION 9D.5.1.7							
Feedback on results of safety and performance improvement activities are regularly communicated to the staff to promote transparency, shared learning, and active engagement in improvement initiatives.	1. Results on safety and performance improvement activities are accessible to staff through education sessions, meetings and digital communications.						
CRITERION 9D.5.1.8							
Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.	1. Documentation on performance improvement activities and performance indicators; and						
	2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						
CRITERION 9D.5.1.9							
Organisations should develop, review and test a disaster recovery plan. The disaster could be natural (e.g. floods, earthquakes, hurricanes, disease	1. Documentation on training of emergency or contingency plan;						
	2. Attendance list;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
outbreaks), or manmade (e.g. urban fires, industrial accidents, bioterrorism).	3. Evidence of practice drills eg fire drills; and						
	4. Scheduling of drills in the organization's annual plan.						
CRITERION 9D.5.1.10							
Validation process e.g. audits for performance improvement activities shall be conducted by the first and second parties. First party audit shall be performed within the organisation Second party audit is by an external party validating the processes of the organisation.	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; and					
		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.						

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SERVICE SUMMARY	
OVERALL RATING :	
OVERALL RISK :	

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SERVICE STANDARD 09E : CLINICAL SERVICES – CARDIOLOGY SERVICES

PREAMBLE

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:

a) appropriateness of clinical care

b) unwarranted variation in care that is not explained by the clinical circumstances or personal choices of the medical practitioners in:-

i) overuse of treatments or procedures that do not help patients get better;

ii) underuse of care; and

iii) misuse (or errors) of doing something incorrectly and harming patients.

TOPIC 9E.1
ORGANISATION AND MANAGEMENT

STANDARD 9E.1.1

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.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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	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 are measurable in line with the Facility statements available, endorsed and dated;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.	3. Evidence of planned reviews of the above statements (at least once in 3 years or in the event of any major changes);						
	4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc); and						
	5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.						
CRITERION 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:	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; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
i) Organisation; ii) Functions; iii) Reporting relationships; iv) Staffing patterns.	3. The organisation chart is revised when there is a major change in any of the items (c)(i) to (iv).						
CRITERION 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; 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.	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; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	6. Proper and adequate equipment according to current standards.						
CRITERION 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.	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; and						
	3. Minutes of meetings of MDAC/Management.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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; and						
	3. Minutes of meeting of Senior Management Team.						
CRITERION 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.	1. Documentation of departmental policy and procedures;						
	2. Medical Staff By-Laws; clause indicate clinical care responsibility of cardiologist; and						
	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, as well as patient care plan including the results of diagnostic tests, valid name stamp of cardiologists/medical practitioners.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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; 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; and e) Safety and performance improvement activities and risk management.	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; and						
	5. Implementation of performance improvement activities.						
CRITERION 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	1. Minutes are accessible, disseminated and acknowledged by the staff;						
	2. Attendance list of members with adequate representation of the service;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented	3. Frequency of meetings as scheduled; and						
	4. Discussion and resolutions are implemented.						
CRITERION 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; and c) Appropriate supervision and training are given to the medical practitioners, nurses and paramedics concerned.	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; and						
	4. Log books.						
CRITERION 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.	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)					

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	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; and						
	h. Data on performance improvement activities, including performance indicators.						
CRITERION 9E.1.1.11							
The Governing Body shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible	1. Documented and approved BCP for unanticipated situations;						
	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
staff, and alternative arrangements to continue care.	c. Assigned ownership, and d. Risk treatment.						
	3. Clear actions and staff responsibilities during disruption;						
	4. Record of drills or tests, with follow-up actions, if conducted; and						
	5. Review of Risk Register.						

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TOPIC 9E.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD 9E.2.1
CREDENTIALING AND PRIVILEGING
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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;	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;						
	4. Recommendations from peer/referee;						
	5. Availability of the list of specialised procedures requiring privileging; and						
	6. Availability of list of specialised procedures specific to the disciplines performed by medical officers; competency records/logbooks.						

DISTRIBUTION

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and g) The recommendations of the relevant department and/or major professional services for privileges to be granted are taken into consideration.							
CRITERION 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	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/logbooks;						
	5. Annual Practising Certificate (APC) and privileging certificate;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and g) The recommendations of the relevant department and/or major professional services for privileges to be granted are taken into consideration.	6. Availability of the list of specialised procedures requiring privileging; and						
	7. Availability of list of specialised procedures specific to the disciplines performed by medical officers.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Formal letter of assignment or certificate of privileging with stipulated timeline are issued and reviewed accordingly; and						
	2. Updated list of staff with privileges conferred is made accessible at point of care.						
CRITERION 9E.2.1.4							
Clinical staff performs procedures within the privileges conferred.	1. Verification of procedures performed by individuals at point of care within the awarded privileging rights with evidence of:						
	a. List of procedures privileged; and						
	b. Clinical notes.						
CRITERION 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;	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;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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ii) Duties and responsibilities; iii) General and specific accountabilities; iv) Qualifications required and privileges granted; v) Staffing patterns; and vi) Statutory Regulations. e) Administrative and clinical functions.	3. Relevant privileges granted where applicable; and						
	4. The job description is acknowledged by the staff and signed by the Head of Service and dated.						

STANDARD 9E.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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	4. Certificate of attendance/degree/post basic training.						
CRITERION 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.	1. Evidence of inclusion of results of audit activities, e.g. mortality and morbidity reviews, incident reporting, etc in educational activities; and						
	2. Evidence of improvement made from corrective or preventive measures from incident reports.						
CRITERION 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	1. Sufficient skilled trained staff to provide clinical supervision as per terms of Memorandum of Understanding.						
CRITERION 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.	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; and						
	4. Training module.						

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

STANDARD 9E.2.3
STAFFING LEVEL AND STAFF COMPETENCY
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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	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						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.							

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Standard 9E.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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9E.2.4.1							
There is a structured orientation programme for all newly appointed, contracted and outsourced staff to the Services that include but not limited to the following: <u>General</u> a) Vision and mission of the Facility; b) Organisation chart and reporting structure of the Facility; c) Environment and facility safety policies and procedures including sustainability practices; d) Infection control policies and procedures; e) Policies for performance management, patient safety (IPSG/MPSG) and risk management; f) Ethical practices and code of conduct including medicolegal awareness; g) Management of aggression, violence and harassment; and h) Patient and family rights; <u>Services</u>	1. Policy requiring all new staff to attend a structured orientation programme; 2. There is Services orientation programme with relevant topics not limited to topics covered from (a) to (q); and 3. Attendance list.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
i) Goals, objectives and organisational structure of Services; j) Policies and procedures relevant to Services; k) Working instructions for patient care; and l) Service continuity plan for Services in response to internal and external disasters <u>Job-specific</u> m) Explanation of particular duties and functions; n) Explanation of the methods of assigning clinical care and the standards of clinical practice; o) Handover communication; p) Training in basic/advanced life support techniques; and q) Technology and equipment use including artificial intelligence, digital care and robotics							

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STANDARD 9E.2.5 (NEW)

The cardiology services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the cardiology staff, ensuring a safe and healthy work environment.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9E.2.5.1 (CORE)							
The Cardiology services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being. a) A health-promoting environment, e.g., stress management, burn out, staff engagement opportunities, workload monitoring, management of work life balance, healthy, lifestyle programmes e.g. Workplace Wellness Programs, Community-Based Health Initiatives; b) Staff shall be provided with appropriate supervision, support, and advice e.g., mentor mentee program; and c) There shall be clear procedures for the effective management of underperformance e.g., feedback on performance review or performance appraisal report.	1. The promotion of staff well-being may involve the following:						
	a. Evidence of a health promoting environment eg., workplace wellness programme;						
	b. Evidence of proper supervision of staff; and						
	c. Evidence of staff appraisal programme with feedback on underperformance.						
CRITERION 9E.2.5.2 (CORE)							
The cardiology services shall establish a safe mechanism for Cardiology Services staff to express grievances, provide	1. Cardiology staff suggestions and grievance reporting and processing mechanisms are available;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety.	2. The resolution of workplace issues may involve the following:						
	a. Measures and evidence of cardiology staff protection including whistleblowers against violence, bullying, and harassment e.g., awareness campaigns, anonymous reporting channel, Whistleblower policy; and						
	b. Documented policies and procedures for violence activation and cardiology staff protection.						
CRITERION 9E.2.5.3 (NEW)							
A system shall be created to gather cardiology staff feedback such as burnout about their workplace experience which shall be analysed and used to make improvements that enhance the work environment, cardiology staff satisfaction, and organisation culture.	1. Staff feedback (e.g., minutes of sessions or staff satisfactions survey):						
	a. Evidence of action or improvement taken.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9E.2.5.4 (NEW)							
The cardiology services shall track sick leave and cardiology staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning	1. Evidence that workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments. The results shall be used to create focused actions that improve cardiology staff well-being, solve problems, and help retain cardiology employees.						

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TOPIC 9E.3
POLICIES AND PROCEDURES

STANDARD 9E.3.1
DEVELOPMENT, DERIVATION AND DOCUMENTATION
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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, current standard practices and Patients and Family Rights. 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.	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; and						
	4. The policies and procedures are endorsed and dated.						
CRITERION 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	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; and						

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with reference to relevant sources involved. Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.	3. Documented cross departmental policies.						
CRITERION 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 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;	1. Documented policies and procedures that address but not limited to (a) to (p).						

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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 onsite cardiothoracic surgery backup; n) End of life care; o) Management of a death; and p) Sedation used during invasive procedures, ie. Transoesophageal Echocardiogram (TOE), coronary angiogram, PCI etc.							
CRITERION 9E.3.1.4							
Current policies and procedures are communicated to all staff	1. Training and briefing on the current policies and procedures/Minutes of meetings; and						
	2. Circulation list and acknowledgement.						
CRITERION 9E.3.1.5 (CORE)							
Policies and procedures are integrated in the care of	1. Compliance with policies and procedures through:						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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cardiology patients incorporating but not limited to following pathways: a) Admission process; b) Preoperative assessment; c) Intraoperative protocols; d) Post-anaesthesia care; e) Transition of care process; f) Surgical site infection prevention; g) Day of surgery admission protocols; h) Environment of care for cardiology patients; and i) Discharge process. There is evidence of compliance with policies and procedures on various types of patients.	a. Interview of staff on practices;						
	b. Verify with observation on practices;						
	c. Results of audit on practices; and						
	d. Practices in line with established policies and procedures.						
CRITERION 9E.3.1.6							
Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.						
CRITERION 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,	1. Operational policy on 24-hour services;						
	2. Staffing level reflects good mix of experienced staff and the intensity of activities during each shift; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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there is a written policy for referral of patients to the nearest facilities where such facilities exist to render optimum treatment to the patient.	3. On-call roster is dated and authorised.						

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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.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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; and						
	5. Absence of overcrowding.						
CRITERION 9E.4.1.2							
Existing facilities shall take cognisance of the safety of staff and patients.	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;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	2. Adequate equipment and supplies for Cardiology Services, e.g. emergency trolley, functioning patient call bell, etc; and						
	3. Equipment should have scheduled planned preventive maintenance (PPM).						
CRITERION 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.	1. Appropriate telecommunication modalities available for daily operation and during emergencies.						
CRITERION 9E.4.1.4 (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care.						

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STANDARD 9E.4.2
FACILITIES AND EQUIPMENT FOR PATIENT CARE
Adequate facilities and equipment shall be available to provide safe and effective patient care.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9E.4.2.1							
Facilities are suitably located to facilitate easy access and to provide an atmosphere of user, environmental and 'disabled' friendly.	1. Floor plan indicates accessibility and patient and user friendly;						
	2. Feedback from patient satisfaction survey; and						
	3. Incident reporting relating to facilities if any.						
CRITERION 9E.4.2.2							
Equipment, both for emergency and non-emergency usage, shall be appropriate to the level of care.	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; and						
	2. Scheduled checking of items in emergency trolley.						
CRITERION 9E.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); and						
	2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as evidence						

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	of compliance to the relevant standards and Acts.						
CRITERION 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.	1. Planned Preventive Maintenance records such as schedule, stickers, etc;						
	2. Planned Replacement Programme where applicable;						
	3. Complaint records; and						
	4. Asset inventory.						
CRITERION 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.	1. User training records;						
	2. Competency assessment record;						
	3. Letter of authorisation; and						
	4. List of staff trained and authorised to operate specialised equipment.						
CRITERION 9E.4.2.6							
Equipment upgrades shall consider energy efficiency ratings	1. Equipment are being replaced and upgraded to meet current standards of care and advancement in						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
and environmental impact alongside clinical effectiveness.	technology in a planned, systematic, and efficient manner; and						
	2. Energy consumption specifications for all proposed equipment, Energy Star certification or equivalent for applicable devices.						

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.

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CRITERION 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-	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;					

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
ambulant patients and is easily identified through adequate signage; e) The clinic is located close to other facilities, e.g. Radiology, laboratories and pharmacy; and f) Adequate provision is made for patient comfort.	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; and						
	j. Adequate waiting area, rest rooms, refreshments, reading material and parking space.						
CRITERION 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); and c) Performance of various tests where applicable.	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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TOPIC 9E.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

Standard 9E.5.1
The Head of Cardiology Services shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of Cardiology Services.

The Head of Cardiology Services shall ensure compliance to monitoring of specific performance indicators.

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CRITERION 9E.5.1.1							
There are periodical 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; and g) Innovation.	1. Planned performance improvement activities include (a) to (g);						
	2. Records on performance improvement activities;						
	3. Minutes of performance improvement meetings;						
	4. Performance improvement studies;						
	5. Mortality and morbidity audits with remedial actions; and						
	6. Records on innovation if available.						
CRITERION 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	1. Minutes of meetings;						
	2. Letter of assignment of responsibilities; and						

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individual/personnel within the respective services.	3. Job description.						
CRITERION 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.	1. System for incident reporting is in place, which include:						
	a. Training of staff;						
	b. Policy on incident reporting;						
	c. Methodology of incident reporting; and						
	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; and						
	8. Feedback given to staff regarding incident reporting.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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. 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.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9E.5.1.5 (CORE)							
There is tracking and trending of specific performance indicators of the following where appropriate: a) Mortality and morbidity review of patients with acute myocardial infarction (Target: Mortality review - 100%; Morbidity discussion based on the department's discretion); b) Percentage of "Normal" Diagnostic Angiogram (Target: <5%); c) Major complication rate during Diagnostic Coronary Angiogram (Death, acute myocardial infarction, stroke) (Target: <1%); d) Major complication rate during Percutaneous Coronary Intervention (Death, Acute Myocardial Infarction Stroke). (Target: ≤1%); e) Percutaneous Coronary Intervention (PCI) within 90 minutes after diagnosed as acute myocardial infarction "Door to Balloon" Time (Target: 90%); f) Percentage of high risk Acute Coronary Syndrome (ACS) cases undergoing Cardiac Catheterisation during the index admission (Target: > 90%);	1. Specific performance indicators monitored;						
	2. Records on tracking and trending analysis;						
	3. Minutes of mortality/morbidity audits meeting; and						

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g) Percentage of Heart Failure Mortality Rate during index hospitalisation. (Target: ≤10%); and h) Percentage of Heart Failure Readmission Rate at 1-month. (Target: ≤15%). Formation of a sustainability committee that meets quarterly to plan and review sustainability initiatives that show incremental improvements	4. Remedial measures taken where appropriate.						
CRITERION 9E.5.1.6 (NEW)							
The Services participates in the Facility's safety culture assessment. The results are utilized by Service leadership to inform and guide efforts to improve the culture of safety within the Service.	1. Safety Culture Survey for staff.						
CRITERION 9E.5.1.7							
Feedback on the results of safety and performance improvement activities is regularly communicated to the staff to promote transparency, shared learning, and active engagement in improvement initiatives.	1. Results on safety and performance improvement activities are accessible to staff through education sessions, meetings and digital communications.						
CRITERION 9E.5.1.8							
Appropriate documentation of safety and performance improvement activities is kept	1. Documentation on performance improvement activities and performance indicators; and						

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and confidentiality of medical practitioners, staff and patients is preserved.	2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						

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TOPIC 9E.6
SPECIAL REQUIREMENTS

Standard 9E.6.1
INVASIVE CARDIAC LABORATORY SERVICES

9E.6.1.1 STAFFING, PROCESS AND SAFETY REQUIREMENTS
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.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9E.6.1.1.1 (CORE)							
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.	1. Cardiologists registered with National Specialist Register (NSR);						
	2. Letter of appointment/assignment; and						
	3. Staff are credentialed and certified by approved institutions.						
CRITERION 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.	1. Monthly monitoring of dosimetry by the licensed agency/laboratory approved by Atomic Energy Licensing Board (AELB), Malaysia.						

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CRITERION 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.	1. Documented evidence on involvement in interdepartmental committees, e.g. letters of appointment, etc.						
CRITERION 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. Consent shall include disclosure if the centre is without on-site	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); and						
	c. Content of patient records;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
surgical backup and its potential implications; 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.	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.						
	d. Documentation in the patients' records to include:						
	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.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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	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.						
CRITERION 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; d) 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	1. Documentation of guidelines to address (a) to (d); and 2. Verify compliance to guidelines during survey.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
on-site surgical backup); vii) Rotational or other atherectomy shall not be done in centres WITHOUT on- site surgical backup; viii) Structural Interventions (Transcatheter Aortic Valve Implantations, Transcatheter Edge-to-edge Repairs, Defect closures, etc), Interventional Electrophysiological Procedures, Interventional Imaging etc are to be done with adherence to guidelines, ensuring patient and staff safety; ix) For units embarking on structural intervention program, demonstrate performance improvement plan focusing on key quality indicators such as patient outcome; x) Maintain documentation on staff credential, training record and performance evaluation; xi) To conduct complex interventions, to ensure cath lab is equipped mechanical circulatory							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
support such as balloon pump etc; and xii) Implementation of digital healthcare components and AI domains.							
CRITERION 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; and 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;	1. Invasive Cardiac Laboratory Services records which include items listed (a) to (c); and						
	2. Patient care plan including the results of diagnostic tests.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
vi) Proposed care plan; vii) Personnel involved; viii) Post-investigative orders; and ix) Reports of all investigative findings shall be signed by cardiologist.							
CRITERION 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.	1. On-site ICU/CCU and blood bank services available; and						
	2. Cardiothoracic surgeon on-site or agreement with other facility providing cardiothoracic surgery support.						
CRITERION 9E.6.1.1.8 (CORE)							
Anaesthetic services, where required, in the Invasive Cardiac Laboratory are consistent with standards in the operating suite.	1. Facilities for anaesthetic services are maintained at same standard as the operating suite.						
CRITERION 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.	1. Verify compliance with recommendations of the International Commission of Radiation Protection (ICRP) on-site.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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CRITERION 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	1. Documentation on safety precautions is signed by designated personnel; and						
	2. Compliance with safety precautions against radiation hazards and other hazards are monitored and documented.						
CRITERION 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.	1. Valid license is available.						
	2. Records on yearly inspection of records on rooms and equipment.						
CRITERION 9E.6.1.1.12 (CORE)							
Multilingual signs warning women of childbearing age about radiation dangers shall be prominently displayed.	1. Availability of multilingual signs warning women of childbearing age about radiation dangers.						

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9E.6.1.2
FACILITIES FOR INVASIVE CARDIAC LABORATORY
There are appropriate and adequate physical facilities and equipment for the safe and efficient functioning of the Invasive Cardiac Laboratory Services.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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; and f) Staff change and scrub rooms.	1. Services as approved in the current Facility's licence;						
	2. Design of the Invasive Cardiac Laboratory Services include (a) to (f); and						
	3. Space area complies with requirements from Radiation Safety Section, Engineering Services Division, Ministry of Health Malaysia.						
CRITERION 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;	1. Design of the Invasive Cardiac Laboratory Services complies with fire safety requirements which include (a) to (d); and						
	2. Complies with requirements from Radiation Safety Section,						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
b) Adequate means of egress from the laboratory in the event of fire; c) Ready access for routing emergency patients; and d) Free movement of patient trolleys throughout the laboratory with minimum cross traffic.	Engineering Services Division, Ministry of Health Malaysia.						
CRITERION 9E.6.1.2.3 (CORE)							
Other systems include: a) Adequate numbers of general power outlets distributed according to the 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; and f) Fluoroscopy units shall have image intensifiers.	1. Invasive Cardiac Laboratory equipped with features listed (a) to (f); and						
	2. Compliance with requirements from Radiation Safety Section, Engineering Services Division, Ministry of Health Malaysia.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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; and 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 milliamp R.C.D's or a Safety Switch which is the same as in most houses but more sensitive to Earth Leakage Currents.	1. Safety features as stated in (a) to (d) are addressed in Invasive Cardiac Laboratory; and						
	2. Safety features comply with requirement from Radiation Safety Section, Engineering Services Division, Ministry of Health Malaysia.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9E.6.1.2.5 (CORE)							
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); and						
	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.						
CRITERION 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 / Explainations** 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	1. Planned Preventive Maintenance records, such as schedule, stickers, etc;						
	2. Planned Replacement Programme where applicable;						
	3. Complaint records; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
tested as a routine e.g. defibrillator is discharged and output checked every day or after each use and the result is recorded.	4. Asset inventory.						
CRITERION 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.	1. User training records;						
	2. Competency assessment record;						
	3. Letter of authorisation; and						
	4. List of staff trained and authorised to operate specialised equipment.						

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Standard 9E.6.2
NON - INVASIVE CARDIAC LABORATORY SERVICES

Standard 9E.6.2.1
STAFFING, PROCESS AND SAFETY REQUIREMENTS
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Cardiologists registered with National Specialist Register (NSR);						
	2. Letter of appointment/assignment; and						
	3. Staff are credentialed and certified by approved institutions.						
CRITERION 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.	1. Credentialing and privileging process in place; and						
	2. List of personnel privileged and for specific procedures.						

DISTRIBUTION

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9E.6.2.1.3 (CORE)							
The results of tests shall be reported and signed by the cardiologist/physician with adequate training.	1. Results of tests are reported and signed by the cardiologist/physician with adequate training.						
CRITERION 9E.6.1.2.4 (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.	1. Documented evidence on involvement interdepartmental committees, e.g. letters of appointment, etc; and 2. Minutes of Meetings.						
CRITERION 9E.6.1.2.5 (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	1. Policies and procedures address items (a) to (j);						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and j) The role of the Non-Invasive Cardiac Laboratory staff in the fire and disaster plans of the Facility.							
CRITERION 9E.6.1.2.6 (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; and d) HOLTER monitoring.	1. A manual of Technical Procedures and Routines which include investigations listed (a) to (d) are available.						
CRITERION 9E.6.1.2.7 (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.	1. Observation on compliance with guidelines during survey						
CRITERION 9E.6.1.2.8 (CORE)							
Non-Invasive Cardiac Laboratory Services records are adequate for clinical, medicolegal, and evaluation purposes and these include the following:	1. Non-Invasive Cardiac Laboratory Services records include items listed (a) to (b).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
a) Standard drug administration records are maintained, and statutory regulations relating to the control of drugs are followed; and 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.							
CRITERION 9E.6.1.2.9 (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.	1. On-site ICU/CCU services available; and						
	2. Cardiothoracic surgeon on-site or agreement with other facility providing cardiothoracic surgery support.						
CRITERION 9E.6.1.2.10 (CORE)							
Safety instruction and safety precautions are implemented for the protection of both patients and staff.	1. Safety instructions and safety precautions are available; and						
	2. Observation on implementation of safety precautions during survey.						

STANDARD 9E.6.2.2
NON-INVASIVE CARDIAC LABORATORY SERVICES
FACILITIES FOR NON-INVASIVE CARDIAC LABORATORY
There are appropriate and adequate physical facilities and equipment for the safe and efficient functioning of the Non-Invasive Cardiac Laboratory.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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; and d) Area for resuscitation.	1. Services as approved in the current Facility's licence; and						
	2. Design of the Non-Invasive Cardiac Laboratory Services includes facilities listed (a) to (d).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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; and d) Free movement of patients throughout the laboratory with minimum cross traffic.	1. Design of the Invasive Cardiac Laboratory Services complies with fire safety requirements which include items listed (a) to (d).						
CRITERION 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; and	1. Non-Invasive Cardiac Laboratory equipped with features listed (a) to (e).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
e) Resuscitation trolley shall be readily available.							
CRITERION 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.	1. Safety features as listed (a) to (b) are addressed in the Non- Invasive Cardiac Laborator.						
CRITERION 9E.6.2.2.5 (CORE)							
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); and						
	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.						
CRITERION 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	1. Planned Preventive Maintenance records, such as schedule, stickers, etc;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.	2. Planned Replacement Programme where applicable; 3. Complaint records; and 4. Asset inventory.						
CRITERION 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.	1. User training records. 2. Competency assessment record. 3. Letter of authorisation. 4. List of staff trained and authorised to operate specialised equipment.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	5. Cardiothoracic surgeon on-site or agreement with other facility providing cardiothoracic surgery support.						

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SERVICE SUMMARY	
OVERALL RATING :	-
OVERALL RISK :	-

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SERVICE STANDARD 09F: CLINICAL SERVICES - ONCOLOGY SERVICES

PREAMBLE

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:

a) appropriateness of clinical care

b) unwarranted variation in care that is not explained by the clinical circumstances or personal choices of the oncologists in:

i) overuse of treatments or procedures that do not help patients get better;

ii) underuse of care; and

iii) misuse (or errors) of doing something incorrectly and harming patients.

TOPIC 9F.1
ORGANISATION AND MANAGEMENT

STANDARD 9F.1.1

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.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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	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 are measurable in line with the Facility statements available, endorsed and dated;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required and communicated to all staff.	3. Evidence of planned reviews of the above statements (at least once in 3 years or in the event of any major changes);						
	4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc); and						
	5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.						
CRITERION 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.	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).						
CRITERION 9F.1.1.3							
The Governing Body shall ensure that the Oncology Services are organised as to:	1. Departmental/Service operational policies that address items (a) to (d);						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and 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.	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; and						
	6. Proper and adequate equipment according to current standards.						
CRITERION 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	1. Letter of appointment/assignment and delineation of duties and responsibilities of the Head of the Service; and						
	2. Letter of appointment and Terms of Reference as member of the Medical and Dental Advisory Committee/Medical Advisory Committee.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and c) Control and to improve activities relating to Oncology Services							
CRITERION 9F.1.1.5 (CORE)							
The Head of Oncology Services has: a) Representation of the Service in committees and subcommittees where relevant; b) Representation of the Service in clinical staff liaison meetings; and c) Involvement and provide regular input to the Senior Management Team.	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; and						
	3. Minutes of meeting of Senior Management Team.						
CRITERION 9F.1.1.6							
The assessment, planning, direction, evaluation and continuity of clinical care are the responsibility of oncologists managing individual	1. Medical Staff By-Laws; clause indicates clinical care responsibility of oncologists; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
patients, thus ensuring clinical independence.	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, as well as patient care plan including the results of diagnostic tests, valid name stamp of medical practitioner.						
CRITERION 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.	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; and						
	4. Implementation of performance improvement activities.						
CRITERION 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.	1. Minutes are accessible, disseminated and acknowledged by the staff;						
	2. Attendance list of members with adequate representation of the service;						
	3. Frequency of meetings as scheduled; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	4. Discussion and resolutions are implemented.						
CRITERION 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; and c) Appropriate supervision and training are given to the medical practitioners concerned.	1. Logbooks;						
	2. Assessment reports; and						
	3. Training timetable, continuing medical education and attendances list.						
CRITERION 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.	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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9F.1.1.11							
The Head of Services shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	1. Documented and approved BCP for unanticipated situations;						
	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment.						
	3. Clear actions and staff responsibilities during disruption;						
	4. Record of drills or tests, with follow-up actions, if conducted;						
	5. Review of Risk Register; and						
	6. Documented and approved BCP for emergency services.						

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TOPIC 9F.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD 9F.2.1
CREDENTIALING AND PRIVILEGING
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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;	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/logbooks;						
	4. Annual Practising Certificate (APC), National Specialist Register (NSR) certificate and privileging certificates;						
	5. Recommendations from peer/referee;						
	6. Availability of the list of specialised procedures requiring credentialing and privileging;						
	7. Availability of list of specialised procedures specific to the disciplines performed by medical officers;						
	8. Only radiation and clinical oncologists can prescribe radiotherapy;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and g) The recommendations of the relevant department and/or major professional services for privileges to be granted are taken into consideration.	9. Only clinical and medical oncologists can prescribe chemotherapy;						
	10. Pharmacist Certification for "Cancer Chemotherapy Preparation" training programme;						
	11. Qualified and Privileged Medical Physicist; and						
	12. Qualified and Privileged nurses and radiographers for Oncology Services.						
CRITERION 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.	1. Formal letter of assignment or certificate of privileging with stipulated timeline are issued and reviewed accordingly; and						
	2. Updated list of staff with privileges conferred is made accessible at point of care.						
CRITERION 9F.2.1.3 (CORE)							
Clinical staff performs within the privileges conferred.	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; and					
		c. Operating notes/clinical notes.					

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9B.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; and 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; and						
	4. The job description is acknowledged by the staff and signed by the Head of Service and dated.						

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Standard 9F.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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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; and						
	4. Certificate of attendance/degree/post basic training.						
CRITERION 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.	1. Evidence of inclusion of results of audit activities, e.g. mortality and morbidity reviews, incident reporting, etc in educational activities; and						
	2. Evidence of improvement made from corrective or preventive measures from incident reports.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Sufficient skilled trained staff to provide clinical supervision as per terms of Memorandum of Understanding.						
CRITERION 9F.2.2.4 (CORE)							
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.	1. 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;						
	2. A staff development plan based on training needs assessment is available;						
	3. Training schedule/calendar is in place; and						
	4. Training module, e.g. safe handling of cytotoxic drugs, spill or leak management etc.						
CRITERION 9F.2.2.5							
Staff including medical Staff including oncologists receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.	1. Performance appraisal for staff including oncologists is completed upon probationary period and as an annual exercise.						

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

STANDARD 9F.2.3
STAFFING LEVEL AND STAFF COMPETENCY
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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	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; and						
	d. Duty roster						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and 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.							

STANDARD 9F.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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9F.2.4.1							
There is a structured orientation programme for all newly appointed, contracted and outsourced staff to the Services that include but not limited to the following:	1. Policy requiring all new staff to attend a structured orientation programme.						
	2. There is Services orientation programme with relevant topics not limited to topics covered from (a) to (q).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
General a) Vision and mission of the Facility b) Organisation chart and reporting structure of the Facility c) Environment and facility safety policies and procedures including sustainability practices d) Infection control policies and procedures e) Policies for performance management, patient safety (IPSG/MPSG) and risk management f) Ethical practices and code of conduct including medicolegal awareness g) Management of aggression, violence and harassment h) Patient and family rights Services i) Goals, objectives and organisational structure of Services j) Policies and procedures relevant to Services k) Working instructions for patient care l) Service continuity plan for Services in response to internal and external disasters Job-specific m) Explanation of particular duties and functions	3. Attendance list.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
n) Explanation of the methods of assigning clinical care and the standards of clinical practice o) Handover communication p) Training in basic/advanced life support techniques q) Technology and equipment use including artificial intelligence, digital care and robotics							

STANDARD 9F.2.5 (NEW)

The oncology services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the surgical related staff, ensuring a safe and healthy work environment.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9F.2.5.1 (CORE)							
The services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being. a) A health-promoting environment, e.g., stress management, burn out, staff engagement opportunities, workload monitoring, management of work life balance, healthy, lifestyle programmes e.g. Workplace Wellness Programs, Community-Based Health Initiatives;	1. The promotion of staff well-being may involve the following:						
	a. Evidence of a health promoting environment e.g., workplace wellness programme.						
	b. Evidence of proper supervision of staff.						
	c. Evidence of staff appraisal programme with feedback on underperformance.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
b) Staff shall be provided with appropriate supervision, support, and advice e.g., mentor mentee program; and c) There shall be clear procedures for the effective management of underperformance e.g., feedback on performance review or performance appraisal report.							
CRITERION 9F.2.5.2 (CORE)							
The Oncology Services shall establish a safe mechanism for surgical staff to express grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety.	1. Oncology staff suggestions and grievance reporting and processing mechanisms are available;						
	2. The resolution of workplace issues may involve the following:						
		a. Measures and evidence of surgical staff protection including whistleblowers against violence, bullying, and harassment e.g., awareness campaigns, anonymous reporting channel, Whistleblower policy; and					
		b. Documented policies and procedures for violence activation and oncology staff protection.					
CRITERION 9F.2.5.3 (NEW)							
A system shall be created to gather staff feedback about their	1. Staff feedback (e.g., minutes of sessions or staff satisfactions survey):						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
workplace experience such as burnout which shall be analysed and used to make improvements that enhance the work environment, staff satisfaction, and organisation culture.	a. Evidence of action or improvement taken.						
CRITERION 9F.2.5.4 (NEW)							
The oncology related services shall track sick leave and oncology staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning	1. Evidence that workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments. The results shall be used to create focused actions that improve surgical staff well-being, solve problems, and help retain oncology employees.						

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TOPIC 9F.3
POLICIES AND PROCEDURES

STANDARD 9F.3.1
DEVELOPMENT, DERIVATION AND DOCUMENTATION
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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, current standard practices and Patients and Family Rights. 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.	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; and						
	4. The policies and procedures are endorsed and dated.						
CRITERION 9F.3.1.2							
Policies and procedures are developed by a committee in collaboration with staff, medical practitioners,	1. Minutes of committee meetings on development and revision on policies and procedures;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.	2. Minutes of meeting with evidence of cross reference with other departments; and						
	3. Cross departmental policies.						
CRITERION 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 5th 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;	1. Documented policies and procedures that address but not limited to items (a) to (o);						
	2. Checklist for patient chart documentation:						
		a. history and physical examination;					
		b. past medical history;					
		c. review of systems and review of imaging studies and laboratory data;					
		d. histopathology diagnosis; and					
		e. recommendations for treatment & shared decision making					
	3. Treatment prescriptions should include planning and checklist for chemotherapy, radiation therapy and brachytherapy where applicable.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and o) Patient and Family Rights pertaining to the service							
CRITERION 9F.3.1.4							
Current policies and procedures are communicated to all staff.	1. Training and briefing on the current policies and procedures/ Minutes of meetings; and						
	2. Circulation list and acknowledgement.						
CRITERION 9F.3.1.5 (CORE)							
Policies and procedures are integrated in the care of patients incorporating but not limited to the following: a) Admission process; b) Post-anaesthesia care;	3. 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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
c) Transition of care process; d) Surgical site infection prevention; e) Day of surgery admission protocols; f) Environment of care for surgical patients; and g) Discharge process There is evidence of compliance with policies and procedures on various types of patients.	d. Practices in line with established policies and procedures.						
CRITERION 9F.3.1.6							
Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.	1. Copies of relevant policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.						
CRITERION 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.	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; and						
	4. Observation for compliance with policy.						

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TOPIC 9F.4
FACILITIES AND EQUIPMENT

STANDARD 9F.4.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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	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; and						
	5. Absence of overcrowding.						
CRITERION 9F.4.1.2							
Existing facilities shall take cognisance of the safety of staff and patients.	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;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	2. Adequate equipment and supplies for Oncology Services, e.g. emergency trolley, functioning patient call bell, etc; and						
	3. Equipment should have scheduled planned preventive maintenance (PPM).						
CRITERION 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.	1. Appropriate telecommunication modalities available for daily operation and during emergencies.						
CRITERION 9F.4.1.4 (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care.						

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Standard 9F.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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9F.4.2.1							
Facilities are suitably located to facilitate easy access and to provide an atmosphere of user, environmental and 'disabled' friendly.	1. Floor plan indicates accessibility and patient and user friendly;						
	2. Feedback from patient satisfaction survey; and						
	3. Incident reporting relating to facilities if any.						
CRITERION 9F.4.2.2							
Equipment, both for emergency and non-emergency usage, shall be appropriate to the level of care.	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.						
CRITERION 9F.4.2.3							
There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.	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);						
	3. Biological Safety Cabinet (BLSC) for preparation of chemotherapy						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	drugs comply with Class II Type B or better, externally-vented BLSC which must have airflow monitoring devices and be certified every year; and						
	4. Sterile disposable equipment is used for all cancer chemotherapy drugs, luer-lock devices etc.						
CRITERION 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.	1. Planned Preventive Maintenance records such as schedule, stickers, etc;						
	2. Planned Replacement Programme where applicable;						
	3. Complaint records; and						
	4. Asset inventory.						
CRITERION 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.	1. User training records;						
	2. Competency assessment record;						
	3. Letter of authorisation; and						
	4. List of staff trained and authorised to operate specialised equipment.						
CRITERION 9F.4.2.6							
Equipment is upgraded (based on evidence) from time to time so as to keep pace with advancement in operative and	1. Equipment are being replaced and upgraded to meet current standard of care and advancement in						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
diagnostic techniques and technology.	technology in a planned and systematic manner.						

STANDARD 9F.4.3
FACILITIES FOR ONCOLOGY 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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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;	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;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
f) Adequate provision is made for patient comfort; g) Vital signs monitoring at visits; h) Staff aware of all available emergency responses (eg code blue, grey, red etc activation mechanisms) - notices on the above pathways are easily accessible; and i) Pathway of handling ill patients at clinic is available and known to all health care.	h. Floor plan indicates accessibility to supporting services and optimisation of space;						
	i. Adequate patient personal use items, e.g. Wheelchair, etc; and						
	j. Adequate waiting area, rest rooms, refreshments, reading material and parking space.						
CRITERION 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.	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; and						
	d. List of procedures done.						

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TOPIC 9F.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 9F.5.1.
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9F.5.1.1 (CORE)							
There are periodical 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 g) Innovation.	1. Planned performance improvement activities include (a) to (g)						
	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.						
CRITERION 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	1. Minutes of meetings						
	2. Letter of assignment of responsibilities						
	3. Job description						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	4. System for incident reporting is in place, which include:						
		a. Training of staff;					
		b. Policy on incident reporting;					
		c. Methodology of incident reporting; and					
		d. Register/records of incidents.					
	5. Completed incident reports;						
	6. Root Cause Analysis;						
	7. Corrective and preventive action plans;						
	8. Remedial measure;						
	9. Minutes of meetings;						
	10. Acknowledgment by Head of Service and PIC/Hospital Director; and						
	11. Feedback given to staff regarding incident reporting.						
CRITERION 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	1. Performance improvement activities;						
	2. Minutes of meetings; and						
	3. Relevant reports and documents, e.g. clinical audit reports, incident						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	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; and 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.	reports, mortality and morbidity review reports, etc.						
CRITERION 9F.5.1.5							
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	1. Specific performance indicators monitored;						
	2. Records on tracking and trending analysis; and						
	3. Remedial measures taken where appropriate.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
chemotherapy treatment. (Target: less than 0.1%); c) Percentage of oncology systemic therapy prescription (from prescription to administration); and d) Percentage of radiation incident in delivering radiotherapy treatment. (Target: less than 0.5%)							
CRITERION 9F.5.1.6 (NEW)							
The Services participates in the Facility's safety culture assessment. The results are utilized by Service leadership to inform and guide efforts to improve the culture of safety within the Service.	1. Safety Culture Survey for staff.						
CRITERION 9F.5.1.7							
Feedback on the results of safety and performance improvement activities are regularly communicated to the staff to promote transparency, shared learning, and active engagement in improvement initiatives.	1. Results on safety and performance improvement activities are accessible to staff through education sessions, meetings and digital communications.						
CRITERION 9F.5.1.8							
Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.	1. Documentation on performance improvement activities and performance indicators; and						
	2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						

TOPIC 9F.6
SPECIAL REQUIREMENTS

STANDARD 9F.6.1.
RADIOTHERAPY SERVICES
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Valid licence; and						
	2. Approval from Atomic Energy Licensing Board.						
CRITERION 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; and e) Tertiary collimation methods such as multi leaf collimators or block cutting and casting equipment.	1. Availability of equipment (a) to (e) to carry out therapy.						
CRITERION 9F.6.1.3 (CORE)							
Facility that has a brachytherapy machine or radioactive source,	1. Checklist for HDR brachytherapy including for daily quality assurance and treatment planning;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
e.g. Co-60, Ir-192, shall operate in accordance with the relevant laws and statutory requirements: a) High Dose Rate (HDR) Brachytherapy: i) Facilities are as specified by the appropriate authority; and 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) Low Dose Rate (LDR) Brachytherapy: 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; and iv) Facilities for proper storage of all radiation sources are mandatory in accordance to applicable laws. c) Seed Implants	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;						
	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; and						
	6. Items (i) to (iv) for Seed Implants should be addressed by the Facility.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and iv) Patients shall be monitored for radiation prior to discharge to ensure safe radiation levels.							
CRITERION 9F.6.1.4 (CORE)							
There is a fulltime medical physicist trained in radiotherapy who conducts or supervises the calibration, dosimetry, and quality assurance in therapeutic use of radiation including teletherapy and brachytherapy.	1. Availability of trained medical physicist; and						
	2. Specified job description.						
CRITERION 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.	1. Checklist for daily, weekly and monthly check; and						
	2. Recalibration log.						

STANDARD 9F.6.2
RADIATION SAFETY
There is an effective Facility-wide radiation safety programme to deal with radiation hazards to patients, visitors, and staff.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9F.6.2.1 (CORE)							
There are documented safety procedures specific to potentially hazardous areas and for hazardous substances.	1. Documented safety procedures specific to potentially hazardous areas and for hazardous substances;						
	2. Identified hazardous areas;						
	3. Identified hazardous substances; and						
	4. On-site verification on compliance with safety procedures.						
CRITERION 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.	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; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	3. Compliance to usage of personal protective equipment.						
CRITERION 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; and 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.	1. Terms of Reference of Radiation Safety Committee to address items (a) to (e); and						
	2. Minutes of meetings.						
CRITERION 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	1. Safety measures against radiation hazard for patients address items (a) to (d);						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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	2. Documented formal treatment planning system and quality assurance plan should be available; and						
	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; and						
	5. At completion of treatment, a follow-up plan should be documented in the patient notes. Follow-up notes should be documented.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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; and d) Personal radiation badges/monitoring devices are used, properly maintained and detailed records are kept.	1. Safety measures against radiation hazard for staff include but not limited to items (a) to (d).						
CRITERION 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; and b) Control the visit to patients undergoing brachytherapy treatments, e.g. the age and health status of visitors and duration of visit, etc.	1. Safety measures against radiation hazard for visitors include but not limited to items (a) and (b).						

STANDARD 9F.6.3
CHEMOTHERAPY SERVICES
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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 credentialed and privileged oncologists; b) All patients shall be treated according to established chemotherapy protocols, and variances from protocols are monitored; c) Independent double-check of chemotherapy types and patient (recipient) by at least two nurses prior to administration; d) There is evidence of collaborative care among specialists in chemotherapy, surgery, radiotherapy, and palliative medicine for optimum clinical management; and e) All principal clinical support services shall be readily available, e.g. dietetics,	1. Policies and procedures which address items (a) to (e);						
	2. Compliance with policies and procedures;						
	3. Patient's medical record; and						
	4. Patient chart review for evidence of team discussion.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
physiotherapy, occupational therapy, counselling etc.							
CRITERION 9F.6.3.2 (CORE)							
Privileged oncology trainees, medical officers and trained nurses with approved certification or oncologists shall deliver intravenous chemotherapy.	1. Verification of procedure performed by individual at point of care within the awarded privileging rights with evidence of privileging certificates.						
CRITERION 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.	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.						
CRITERION 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.	1. Patient's medical record documentation; and						
	2. Observation/patient interview during survey.						
CRITERION 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 benefits and side effects, e.g. nausea and vomiting, neutropaenic sepsis etc.	1. Patient's consent form for chemotherapy (PCC); and						
	2. Patient and carer orientation checklist.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Functional facilities for reconstitution of chemotherapy drugs as per National Pharmaceutical Control Bureau (BPFK); and						
	2. Trained and certified pharmacist to reconstitute chemotherapy drugs.						

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STANDARD 9F.6.4
RADIOACTIVE AND CYTOTOXIC WASTE

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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; and						
	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.						
CRITERION 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.	1. Compliance with the Environmental Quality Act						

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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.							
CRITERION 9F.6.4.3 (CORE)							
Spillages kits shall be readily available to contain spillage of cytotoxic drugs with documented procedures regarding their usage	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); and						
	c. Personal protective equipment:						
	i. Head cover (1);						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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	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); and						
	viii. Brush and small dustpan (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); and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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	l. Cytotoxic drug spill incident report form (1).						

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SERVICE SUMMARY	
OVERALL RATING :	
OVERALL RISK :	

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SERVICE STANDARD 09I : CLINICAL SERVICES – PSYCHIATRY AND MENTAL HEALTH

PREAMBLE

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.

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 accordance to Mental Health Act 2001 and Mental Health Regulation 2010 and cover the following:

a) Appropriateness of clinical care;

b) Unwarranted variation in care that is not explained by the clinical circumstances or personal choices of the psychiatry practitioners in:

i) Overuse of treatments or procedures that do not help patients get better;

ii) Underuse of care; and

iii) Misuse (or errors) of doing something incorrectly and harming patients.

In addition to the above, the Psychiatry Services also conduct teaching and training, research and audit activities where applicable.

TOPIC 9I.1
ORGANISATION AND MANAGEMENT

STANDARD 9I.1.1

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.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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 are measurable in line with the Facility statements available, endorsed and dated;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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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.	3. Evidence of planned reviews of the above statements (at least once in 3 years or in the event of any major changes);						
	4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc.); and						
	5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.						
CRITERION 9I.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;	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 services endorsed, dated and accessible; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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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.	3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).						
CRITERION 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; and d) Ensure that the psychiatry practitioners are involved in	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; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
the formulation of policies and procedures concerning patient care appropriate to the scope of services of the Facility.	5. Minutes of meetings.						
CRITERION 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; and b) Medical Advisory Committee (MAC) / 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.	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; and 3. Minutes of meetings of MDAC/MAC/Management.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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; and c) Involvement and provide regular input to the Senior Management Team.	1. Letter of representation of the Head of Service in committees and subcommittees where relevant, e.g. Medical Records Committee, Hospital Infection and Antibiotic Control Committee, etc;						
	2. Minutes of meetings of committees; and						
	3. Minutes of meeting of Senior Management Team.						
CRITERION 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.	1. Medical Staff By-Laws; clause indicate clinical care responsibility of psychiatry practitioners; and						
	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.						
CRITERION 9I.1.1.7							
The Head of Psychiatry Services shall be involved for the following aspects of management of the services:	1. Evidence of (a) to (e) in the minutes of meetings of Psychiatry Services indicate the involvement of Head of Service;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and e) Safety and performance improvement activities and risk management.	2. Endorsement of policies and procedures;						
	3. Request for allocation of budget and staffing;						
	4. Implementation of performance improvement activities; and						
	5. Outcoming monitoring and analysing activities.						
CRITERION 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.	1. Minutes are accessible, disseminated and acknowledged by the staff;						
	2. Attendance list of members with adequate representation of the service;						
	3. Frequency of meetings as scheduled;						
	4. Discussion and resolutions are implemented; and						
	5. Confidentiality and safety of virtual meeting.						
CRITERION 9I.1.1.9							
Where there are psychiatry practitioners in training, there is evidence that:	1. Structured training programmes for psychiatry practitioners are in place;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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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.	2. Training timetable, continuing medical education and attendances list;						
	3. Assessment reports; and						
	4. Logbooks.						
CRITERION 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.	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;						
	2. Data on performance improvement activities, including performance indicators.						
CRITERION 9I.1.1.11							
The Head of Services shall ensure a basic Business	1. Documented and approved BCP for unanticipated situations.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment. 3. Clear actions and staff responsibilities during disruption; 4. Record of drills or tests, with follow-up actions, if conducted; and 5. Review of Risk Register.					

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TOPIC 9I.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

Standard 9I.2.1
CREDENTIALING AND PRIVILEGING
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.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9I.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;	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 specialised procedures requiring credentialing and privileging;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.	6. Availability of list of specialised 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; and						
	9. Privileging and credentialing in Psychological First Aid.						
CRITERION 9I.2.1.2 (CORE)							
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; and						
	2. Updated list of staff with privileges conferred is made accessible at point of care.						
CRITERION 9I.2.1.3							
Clinical staff performs within the privileges conferred.	1. Verification of procedures performed by individuals at point of care within the awarded privileging rights with evidence of:						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	a. List of procedures privileged; and						
	b. Clinical notes.						
CRITERION 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; 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; and						
	5. Understanding of job description.						

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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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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 / apprasial of the training programme; and						
	6. Certificate of attendance/degree/post basic training.						
CRITERION 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	1. Evidence of inclusion of results of audit activities, e.g. mortality and morbidity reviews, incident reporting, etc in educational activities; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
improvement studies and complaints, are taken into consideration when the content and structure of educational activities are planned	2. Evidence of improvement made from corrective or preventive measures from incident reports.						
CRITERION 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 In a Facility where undergraduate medical, nursing and allied health training programmes are conducted, the Facility shall ensure there are sufficient skilled trained	1. Sufficient skilled trained staff to provide clinical supervision as per terms of Memorandum of Understanding.						
CRITERION 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.	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; and						
	5. Training module.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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CRITERION 9I.2.2.5							
completion of the probationary period and annually thereafter, or as defined by the Facility.	1. Performance appraisal for staff including psychiatry practitioners is completed upon probationary period and as an annual exercise.						
CRITERION 9I.2.2.6							
Where appropriate the Facility shall endeavor to undertake clinical research using available resources.	1. Documented evidence of research and quality activities e.g. protocol, policies, consent etc.						

STANDARD 9I.2.3
STAFF TRAINING, EDUCATION, APPRAISAL AND RESEARCH
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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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	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; and					
		c. Contingency plan during acute shortage;					

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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; and 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.	2. Duty roster.						

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STANDARD 9I.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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9I.2.4.1							
There is a structured orientation programme for all newly appointed, contracted and outsourced staff to the Services that include but not limited to the following: <u>General</u> a) Vision and mission of the Facility; b) Organisation chart and reporting structure of the Facility; c) Environment and facility safety policies and procedures including sustainability practices; d) Infection control policies and procedures; e) Policies for performance management, patient safety (IPSG/MPSG) and risk management; f) Ethical practices and code of conduct including medicolegal awareness; g) Management of aggression, violence and harassment; and h) Patient and family rights. <u>Services</u>	1. Policy requiring all new staff to attend a structured orientation programme.						
	2. There is Services orientation programme with relevant topics not limited to topics covered from (a) to (q).						
	3. Attendance list.						

a) Goals, objectives and organisational structure of policies and procedures relevant to services; b) Working instructions for patient care; and c) Service continuity plan for Services in response to internal and external disasters. <u>Job-specific</u> d) Explanation of particular duties and functions; e) Explanation of the methods of assigning clinical care and the standards of clinical practice; f) Handover communication; g) Training in basic/advanced life support techniques; and h) Technology and equipment use including artificial intelligence, digital care and robotics							

STANDARD 9I.2.5

The psychiatry and mental health services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the staff, ensuring a safe and healthy work environment.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9I.2.5.1 (CORE)							
The Psychiatry and Mental Health Services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being.	1. The promotion of staff well-being may involve the following:						
		a. Evidence of a health promoting environment e.g., workplace wellness programme;					

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
a) A health-promoting environment, e.g., stress management, burn out, staff engagement opportunities, workload monitoring, management of work life balance, healthy, lifestyle programmes e.g. Workplace Wellness Programs, Community-Based Health Initiatives; b) Staff shall be provided with appropriate supervision, support, and advice e.g., mentor mentee program; and c) There shall be clear procedures for the effective management of underperformance e.g., feedback on performance review or performance appraisal report.	b. Evidence of proper supervision of staff; and						
	c. Evidence of staff appraisal programme with feedback on underperformance.						
CRITERION 9I.2.5.2 (CORE)							
The psychiatry and mental health services shall establish a safe mechanism for psychiatry and mental health staff to express grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety.	1. Psychiatry and mental health staff suggestions and grievance reporting and processing mechanisms are available;						
	2. The resolution of workplace issues may involve the following:						
	a. Measures and evidence of dental staff protection including whistleblowers against violence, bullying, and harassment e.g., awareness						

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	campaigns, anonymous reporting channel, Whistleblower policy; and						
	b. Documented policies and procedures for violence activation and psychiatry and mental health staff protection.						
CRITERION 9I.2.5.3 (NEW)							
A system shall be created to gather staff feedback about their workplace experience such as burnout which shall be analysed and used to make improvements that enhance the work environment, staff satisfaction, and organisation culture.	1. Staff feedback (e.g., minutes of sessions or staff satisfactions survey);						
	a. Evidence of action or improvement taken.						
CRITERION 9I.2.5.4 (NEW)							
Th The psychiatry and mental health services shall track sick leave and psychiatry and mental health staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning psychiatry and mental health services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being.	Evidence that workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments. The results shall be used to create focused actions that improve psychiatry and mental health staff well-being, solve problems, and help retain dental employees.						

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TOPIC 9I.3
POLICIES AND PROCEDURES

STANDARD 9I.3.1
DEVELOPMENT, DERIVATION AND DOCUMENTATION

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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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, current standard practices and Patients and Family Right. 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.	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; and						
	4. Documented policies and procedures for the service.						
CRITERION 9I.3.1.2 (CORE)							
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	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; and						
	3. Documented cross departmental policies						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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relevant policies and procedures where applicable.							
CRITERION 9I.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 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 psychiatry practitioners in relation to internal and external	1. Documented policies and procedures that address but not limited to (a) to (o)						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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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) Psychiatry-specific topics: i) Suicide risk assessments; ii) Aggression and violence management; iii) Seclusion and restraint; iv) ECT protocols; v) Psychiatric emergency procedures; vi) Forensic psychiatry (if applicable); vii) Continuity of care and discharge planning; and viii) Community mental health referrals							
CRITERION 9I.3.1.4							
Current policies and procedures are communicated to all	1. Training and briefing on the current policies and procedures/ Minutes of meetings;						
	2. Circulation list, acknowledgement and understanding.						
CRITERION 9I.3.1.5 (CORE)							
Policies and procedures are integrated in the care of patients	1. Compliance with policies and procedures through:						

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incorporating but not limited to the following: a) Admission process shall comply to Mental Health Act 2000 and Mental Health Regulation 2010; b) Risk assessment; c) Pre procedure/investigation assessment; d) Intra procedure/investigation protocols; e) Risk monitoring including aggression, absconding and suicidality; f) Inter-discipline care process; g) Prevention and control of infection; h) Environment of care for patient protects patients' safety and confidentiality; and i) Discharge process . There is evidence of compliance with policies and procedures on various types of patients.	a. Interview of staff on practices; b. Verify with observation on practices; c. Results of audit on practices; and d. Practices in line with established policies and procedures						
CRITERION 9I.3.1.6							
Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.	1. Copies of relevant policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.						
CRITERION 9I.3.1.7							
The services shall operate on a 24-hour basis providing a level of	1. Operational policy on 24-hour services;						

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care appropriate to the activities of the patients in the Facility.	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.						

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TOPIC 9I.4
FACILITIES AND EQUIPMENT

STANDARD 9I.4.1
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.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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; and						
	6. Contingency plan.						
CRITERION 9I.4.1.2							
Existing facilities shall take cognisance of the safety & privacy of staff and patients.	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;						

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	2. Clear and safe layout with separation of clean/dirty areas, Adequate, safe lighting, clear, visible signage. Controlled access to sensitive areas. Triage areas allow private, secure risk screening, Consultation rooms have: Panic alarms., Dual exits., Fixed, non-breakable fitting; and						
	3. Equipment should have scheduled planned preventive maintenance (PPM).						
CRITERION 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. The Specialist Outpatient Services shall incorporated digital and AI technologies where applicable.	1. Appropriate telecommunication modalities available for daily operation and during emergencies.						
CRITERION 9I.4.1.4 (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care.						

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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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9I.4.2.1							
Facilities are suitably located to facilitate easy access and to provide an atmosphere of user, environmental and 'disabled' friendly.	1. Floor plan indicates accessibility and patient and user friendly;						
	2. Feedback from patient satisfaction survey; and						
	3. Incident reporting relating to facilities if any.						
CRITERION 9I.4.2.2							
Equipment, both for emergency and non-emergency usage, shall be appropriate to the level of care.	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; and						
	2. Scheduled checking of items in emergency trolley.						
CRITERION 9I.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); and						
	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.						
CRITERION 9I.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.	1. Planned Preventive Maintenance records such as schedule, stickers, etc;						
	2. Planned Replacement Programme where applicable;						
	3. Complaint records; and						
	4. Asset inventory.						
CRITERION 9I.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.	1. User training records;						
	2. Competency assessment record;						
	3. Letter of authorisation; and						
	4. List of staff trained and authorised to operate specialised equipment.						
CRITERION 9I.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.	1. Equipment are being replaced and upgraded to meet current standard of care and advancement in technology in a planned and systematic manner.						

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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.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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; and f) adequate provision is made for patient comfort.	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;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	j. Adequate waiting area, rest rooms, refreshments, reading material and parking space.						
CRITERION 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; and c) Performance of various tests.	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; and						
	d) List of procedures done.						
	2. Competency assessment record						
	3. Letter of authorisation						
	4. List of staff trained and authorised to operate specialised equipment						

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TOPIC 9I.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 9I.5.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9I.5.1.1							
There are periodical 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; and g) Innovation.	1. Planned performance improvement activities include (a) to (g);						
	2. Records on performance improvement activities;						
	3. Minutes of performance improvement meetings;						
	4. Performance improvement studies;						
	5. Mortality and morbidity audits with remedial actions; and						
	6. Records on innovation if available.						
CRITERION 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	1. Minutes of Meetings;						
	2. Letter of assignment of responsibilities; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
individual/ personnel within the respective services.	3. Job description						
CRITERION 9I.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.	1. System for incident reporting is in place, which include:						
	a. Training of staff;						
	b. Policy on incident reporting;						
	c. Methodology of incident reporting; and						
	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; and						
	8. Feedback given to staff regarding incident reporting.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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; and 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; and 3. Relevant reports and documents, e.g. clinical audit reports, incident reports, mortality and morbidity review reports, etc.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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) The number of mortality and morbidity (M&M) audits or meetings conducted within the department; and b) Percentage of unplanned re-admission within 72 hours of discharge percentage of readmission, suggest to follow KKM HPIA of readmission within 48h (target <0.5%) Subspecialties units in the Psychiatry Services: c) Forensic Psychiatry; d) Child and Adolescent Psychiatry; e) Community Psychiatry, etc shall monitor any other two (2) indicators to support its goals and objectives.	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.						
CRITERION 9I.5.1.6 (NEW)							
The Services participates in the Facility's safety culture assessment. The results are utilized by Service leadership to inform and guide efforts to improve the culture of safety within the Service.	1. Safety Culture Survey for staff.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9I.5.1.7							
Feedback on the results of safety and performance improvement activities are regularly communicated to the staff to promote transparency, shared learning, and active engagement in improvement initiatives.	1. Results on safety and performance improvement activities are accessible to staff through education sessions, meetings and digital communications.						
CRITERION 9I.5.1.8							
Appropriate documentation of safety and performance improvement activities is kept and confidentiality of psychiatry practitioners, staff and patients is preserved	1. Documentation on performance improvement activities and performance indicators; and						
	2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						

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SERVICE SUMMARY	
OVERALL RATING :	-
OVERALL RISK :	-

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SERVICE STANDARD 09K: CLINICAL SERVICES – PALLIATIVE CARE SERVICES

PREAMBLE

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:

a) Appropriateness of clinical care;
b) High quality, standardised, timely and safe patient oriented clinical care;
c) Compassionate and empathic communication with patients and families;
d) Coordination of care according to patient needs; and
e) Ethical decision making.

In addition to the above, the Palliative Care Services also conduct teaching and training, and research and audit activities where applicable.

TOPIC 9K.1
ORGANISATION AND MANAGEMENT

STANDARD 9K.1.1

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.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

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CRITERION 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	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 are measurable in line with the Facility statements available, endorsed and dated;						

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monitored, reviewed and revised as required accordingly and communicated to all staff.	3. Evidence of planned reviews of the above statements (at least once in 3 years or in the event of any major changes);						
	4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc.); and						
	5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.						
CRITERION 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.	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; and						
	3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).						
CRITERION 9K.1.1.3							
The Governing Body shall ensure that the Palliative Care Services are organised in such a way as to:	1. Department/Service operational policies that address (a) to (e);						

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a) Ensure timely identification and management of patients with palliative care needs. b) 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; c) assure continuity of care; d) address the professional needs of the medical practitioners; e) 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.	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; and						
	6. Proper and adequate equipment according to current standards.						
CRITERION 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	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; and						
	3. Minutes of meetings of MDAC/Management.						

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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							
CRITERION 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.	1. Letter of representation of the Head of Service in committees and subcommittees where relevant, e.g. Blood Transfusion Committee;						
	2. Minutes of meetings of committees; and						
	3. Minutes of meeting of Senior Management Team.						
CRITERION 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.	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						

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	of time interval & number of different managing practitioners. Evidence of ownership of patients and goals of care discussions in keeping with patient-centered care;						
	3. Documented evidence in clinical notes that there is continuity of care between disciplines and also coordination with other facilities/services to ensure continued support throughout the patient's illness trajectory;						
	4. Documented evidence in clinical notes that the indications for procedures done are valid; and						
	5. Evidence in clinical notes that there is a holistic assessment that covers physical, social, spiritual and psychological needs.						
CRITERION 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;	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; and						

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c) Development of policies and procedures and ensuring compliance to them; d) Facility and equipment management; and e) Safety and performance improvement activities and risk management.	4. Implementation of performance improvement activities (refer to Quality Improvement activities)						
CRITERION 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.	1. Minutes are accessible, disseminated and acknowledged by the staff;						
	2. Attendance list of members with adequate representation of the service;						
	3. Frequency of meetings as scheduled; and						
	4. Discussion and resolutions are implemented.						
CRITERION 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.	1. Structured training programmes for medical practitioners are in place;						
	2. Training timetable, continuing medical education and attendances list;						
	3. Assessment reports; and						
	4. Logbooks.						

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CRITERION 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.	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; and						
	g. Data on patient care outcome measures.						
CRITERION 9K.1.1.11							
The Head of Services shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	1. Documented and approved BCP for unanticipated situations;						
	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment.						
	3. Clear actions and staff responsibilities during disruption;						
	4. Record of drills or tests, with follow-up actions, if conducted; and						

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	5. Review of Risk Register.						

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TOPIC 9K.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD 9K.2.1
CREDENTIALING AND PRIVILEGING
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.

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CRITERION 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: d) The criteria are designed to assure that patients will receive safe and quality care; e) 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; f) Competency for each performance is dated, verified and signed by the supervisors; g) The period of time for which the privileges are to be granted is specified;	1. Documented policies and procedures are established to govern the credentialing and privileging processes which include items (a) to (h);						
	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 specialised procedures requiring credentialing and privileging;						
	6. Availability of list of specialised procedures specific to the disciplines performed by medical officers; competency records/log books; and						
	7. Availability of list of procedures and its outcomes performed by each practitioner if applicable.						

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h) Current registration with the local professional registration bodies, e.g. Malaysian Medical Council, National Specialist Register (NSR); i) Peer recommendations are taken into account when privileges are being considered; j) The recommendations of the relevant department and/or major professional services for privileges to be granted are taken into consideration. k) Outcome of privileged procedures must be documented.	Should be linked to annual appraisal.						
CRITERION 9K.2.1.2 (CORE)							
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; and						
	2. Updated list of staff with privileges conferred is made accessible at point of care.						
CRITERION 9K.2.1.3							
Clinical staff performs within the privileges conferred.	1. Verification of procedures performed by individuals at point of care within the awarded privileging rights with evidence of:						
	a. List of procedures privileged; and						
	b. Clinical notes. The indication for the procedure clearly written.						

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CRITERION 9B.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.	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; and						
	4. The job description is acknowledged by the staff and signed by the Head of Service and dated.						

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STANDARD 9K.2.2
STAFF TRAINING, EDUCATION, APPRAISAL AND RESEARCH
The Facility and all staff shall demonstrate an ongoing commitment to continuing medical education.

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CRITERION 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	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 and basic pain management; and						
	4. Certificate of attendance/degree/post basic training.						
CRITERION 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	1. Evidence of inclusion of results of audit activities, e.g. mortality and morbidity reviews, incident reporting, etc in educational activities; and						

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improvement studies and complaints, are taken into consideration when the content and structure of educational activities are planned.	2. Evidence of improvement made from corrective or preventive measures from incident reports.						
CRITERION 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.	1. Sufficient skilled trained staff to provide clinical supervision as per terms of Memorandum of Understanding; and						
	2. Compliance with locally directed standards of training where applicable.						
CRITERION 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.	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; and						
	4. Training module.						

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CRITERION 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.	5. Performance appraisal for staff including medical practitioners is completed upon probationary period and as an annual exercise.						
CRITERION 9K.2.2.6							
Where appropriate the Facility shall endeavour to undertake clinical research using available resources.	1. Documented evidence of research activities e.g. protocol, policies, consent etc.						

STANDARD 9K.2.3
STAFFING LEVEL AND STAFF COMPETENCY
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.

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CRITERION 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;	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;						

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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; and 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.	d. Duty roster;						
	e. Evidence that staff and doctors are not made to work more than the limits set by different authorities.						
CRITERION 9K.2.3.2							
In a service where volunteers are involved in patient care and support, there should be appropriate training, authorisation and supervision of volunteers.	1. Policy on roles and responsibilities of volunteers;						
	2. Letter of authorisation for volunteers; and						

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	3. Documentation of training session and orientation for volunteers.						

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.

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CRITERION 9K.2.4.1							
There is a structured orientation programme for all newly appointed, contracted and outsourced staff to the Services that include but not limited to the following: <u>General</u> a) Vision and mission of the Facility b) Organisation chart and reporting structure of the Facility c) Environment and facility safety policies and procedures including sustainability practices d) Infection control policies and procedures e) Policies for performance management, patient safety (IPSG/MPSG) and risk management	1. Policy requiring all new staff to attend a structured orientation programme; 2. There is Services orientation programme with relevant topics not limited to topics covered from (a) to (q); and 3. Attendance list.						

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f) Ethical practices and code of conduct including medicolegal awareness g) Management of aggression, violence and harassment h) Patient and family rights <u>Services</u> i) Goals, objectives and organisational structure of Services j) Policies and procedures relevant to Services k) Working instructions for patient care l) Service continuity plan for Services in response to internal and external disasters <u>Job-specific</u> m) Explanation of particular duties and functions n) Explanation of the methods of assigning clinical care and the standards of clinical practice o) Handover communication p) Training in basic/advanced life support techniques q) Technology and equipment use including artificial intelligence, digital care and robotics							

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STANDARD 9K.2.5 (NEW)

The Palliative services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the surgical related staff, ensuring a safe and healthy work environment.

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CRITERION 9K.2.5.1 (CORE)							
The Palliative services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being. a) A health-promoting environment, e.g., stress management, burn out, staff engagement opportunities, workload monitoring, management of work life balance, healthy, lifestyle programmes e.g. Workplace Wellness Programs, Community-Based Health Initiatives; b) Staff shall be provided with appropriate supervision, support, and advice e.g., mentor mentee program; and c) There shall be clear procedures for the effective management of underperformance e.g., feedback on performance review or performance appraisal report.	1. The promotion of staff well-being may involve the following:						
		a. Evidence of a health promoting environment e.g., workplace wellness programme;					
		b. Evidence of proper supervision of staff; and					
		c. Evidence of staff appraisal programme with feedback on underperformance.					

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CRITERION 9K.2.5.2 (CORE)							
The Palliative services shall establish a safe mechanism for Palliative staff to express grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety.	1. Palliative staff suggestions and grievance reporting and processing mechanisms are available;						
	2. The resolution of workplace issues may involve the following:						
	a. Measures and evidence of Palliative staff protection including whistleblowers against violence, bullying, and harassment e.g., awareness campaigns, anonymous reporting channel, Whistleblower policy; and						
	b. Documented policies and procedures for violence activation and staff protection.						
CRITERION 9K.2.5.3 (NEW)							
A system shall be created to gather staff feedback about their workplace experience such as burnout which shall be analysed and used to make improvements that enhance the work environment, staff satisfaction, and organisation culture.	1. Staff feedback (e.g., minutes of sessions or staff satisfactions survey):						
	a. Evidence of action or improvement taken.						
CRITERION 9K.2.5.4 (NEW)							
The Palliative services shall track sick leave and staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning	1. Evidence that workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments. The results shall be						

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	used to create focused actions that improve staff well-being, solve problems, and help retain employees.						

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TOPIC 9K.3
POLICIES AND PROCEDURES

STANDARD 9K.3.1
DEVELOPMENT, DERIVATION AND DOCUMENTATION

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.

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CRITERION 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, current standard practices and Patients and Family Rights. 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.	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; and						
	4. The policies and procedures are endorsed and dated.						
CRITERION 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.	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.						

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Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.	3. Cross departmental policies.						
CRITERION 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 5th vital sign where appropriate; d) Handover communication; e) Essential palliative care drug availability, 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 pain management; h) Pain management; i) Management of patients under police custody/prisoner;	1. Documented policies and procedures that address but not limited to (a) to (q).						

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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 including terminal / compassionate discharge n) Management of a death. o) Grief and Bereavement support p) Effective communication and advance care planning (ACP) q) Emergencies in palliative care							
CRITERION 9K.3.1.4							
Current policies and procedures are communicated to all staff.	1. Training and briefing on the current policies and procedures/ Minutes of meetings; and						
	2. Circulation list and acknowledgement.						

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CRITERION 9K.3.1.5 (CORE)							
Policies and procedures are integrated in the care of patients incorporating but not limited to the following: a) Admission process; b) Preoperative assessment; c) Intraoperative protocols; d) Post-anaesthesia care; e) Transition of care process; f) Surgical site infection prevention; g) Day of surgery admission protocols; h) Environment of care for surgical patients; and i) Discharge process. There is evidence of compliance with policies and procedures on various types of patients.	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; and						
	f. Documentation in clinical notes of goals of care discussions / Advance Care Planning (ACP)						
CRITERION 9K.3.1.6							
Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.	1. Copies of relevant policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.						
CRITERION 9K.3.1.7							
The services shall operate on a 24-hour basis providing a level of	1. Operational policy on 24-hour services;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
care appropriate to the activities of the patients in the Facility.	2. Staffing level reflects good mix of experienced staff and the intensity of activities during each shift; and						
	3. On-call roster is dated and authorised.						

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TOPIC 9K.4
FACILITIES AND EQUIPMENT

STANDARD 9K.4.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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; and						
	7. Availability of private areas for family discussions and care of the dying patient.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9K.4.1.2							
Existing facilities shall take cognisance of the safety of staff and patients.	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; and						
	3. Equipment should have scheduled planned preventive maintenance (PPM).						
CRITERION 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.	1. Appropriate telecommunication modalities available for daily operation and during emergencies.						
CRITERION 9K.4.1.4 (NEW)							
The Palliative Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care.						

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STANDARD 9K.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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9K.4.2.1							
Facilities are suitably located to facilitate easy access and to provide an atmosphere of user, environmental and 'disabled' friendly.	1. Floor plan indicates accessibility and patient and user friendly;						
	2. Feedback from patient satisfaction survey; and						
	3. Incident reporting relating to facilities if any.						
CRITERION 9K.4.2.2							
Equipment, both for emergency and non-emergency usage, shall be appropriate to the level of care.	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; and						
	2. Scheduled checking of items in emergency trolley.						
CRITERION 9K.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); and						
	2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc. as evidence						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	of compliance to the relevant standards and Acts.						
CRITERION 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.	1. Planned Preventive Maintenance records such as schedule, stickers, etc;						
	2. Planned Replacement Programme where applicable;						
	3. Complaint records; and						
	4. Asset inventory.						
CRITERION 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.	1. User training records;						
	2. Competency assessment record;						
	3. Letter of authorization; and						
	4. List of staff trained and authorised to operate specialised equipment.						
CRITERION 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.	1. Equipment are being replaced and upgraded to meet current standard of care and advancement in technology in a planned and systematic manner.						

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STANDARD 9K.4.3
FACILITIES FOR ONCOLOGY 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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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)	1. The Palliative Care Outpatient Services address (a) to (h)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; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
h) Avenue for patients to access service between appointment	j. Adequate waiting area, rest rooms, refreshments, reading material and parking space.						
CRITERION 9K.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.	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.						

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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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9K.5.1.1							
There are periodical 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; and g) Innovation	1. Planned performance improvement activities include (a) to (g);						
	2. Records on performance improvement activities;						
	3. Minutes of performance improvement meetings;						
	4. Performance improvement studies;						
	5. Mortality and morbidity audits with remedial actions; and						
	6. Records on innovation if available.						
CRITERION 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.	1. Minutes of meetings;						
	2. Letter of assignment of responsibilities; and						
	3. Job description.						

DISTRIBUTION

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. System for incident reporting is in place, which include:						
	a. Training of staff;						
	b. Policy on incident reporting;						
	c. Methodology of incident reporting; and						
	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; and						
	8. Feedback given to staff regarding incident reporting.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9K.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. h) 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 Services; iii) In a variety of purpose-specific committees, such as mortality and morbidity, infection control, blood transfusion, etc. i) 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 meeting; and 3. Relevant reports and documents, e.g. clinical audit reports, incident reports, mortality and morbidity review reports, etc.						
CRITERION 9K.5.1.5							
There is tracking and trending of specific performance	1. Specific performance indicators monitored;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
indicators not limited to but at least three (2) of the following: a) Number of unplanned re-admission for the same complaint within 24 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; f) Percentage of patients experiencing procedure related complications (e.g., Infected subcutaneous canula site, infected pigtail catheter, catheter related sepsis etc.); and g) Survey on patient / family experience and satisfaction with service provided.	2. Records on tracking and trending analysis;						
	3. Minutes of mortality/morbidity audits meetings; and						
	4. Remedial measures taken where appropriate.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9K.5.1.6 (NEW)							
The Services participates in the Facility's safety culture assessment. The results are utilized by Service leadership to inform and guide efforts to improve the culture of safety within the Service.	1. Safety Culture Survey for staff.						
CRITERION 9K.5.1.7							
Feedback on results of safety and performance improvement activities are regularly communicated to the staff to promote transparency, shared learning, and active engagement in improvement initiatives.	1. Results on safety and performance improvement activities are accessible to staff through education sessions, meetings and digital communications.						
CRITERION 9K.5.1.8							
Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.	1. Documentation on performance improvement activities and performance indicators; and						
	2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						

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SERVICE SUMMARY	
OVERALL RATING :	
OVERALL RISK :	

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STANDARD 09L: CLINICAL SERVICES – DENTAL SERVICES SERVICE

PREAMBLE

Dental Services encompass the following specialties:

a) Oral & Maxillofacial Surgery;
b) Oral Pathology/ Oral Medicine;
c) Paediatric Dentistry;
d) Forensic Odontology; and
e) Special Care Dentistry.

Dental Services play an integral role in delivering appropriate care and reducing unwarranted adverse events, as they meet the community's expectations regardless of where they are treated in the Facility. The Dental 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:

a) Appropriateness of clinical care; and
b) Unwarranted variation in care that is not explained by the clinical circumstances or personal choices of the medical practitioners in:
  i) overuse of treatments or procedures that do not help patients get better;
  Ii) underuse of care; and
  Iii) misuse (or errors) of doing something incorrectly and harming patients.

In addition to the above, the Dental Services also conduct teaching and training, research and audit activities where applicable.

TOPIC 9L.1
ORGANISATION AND MANAGEMENT

STANDARD 9L.1.1

The Dental 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 Dental Services shall be easily accessible and continuity of care assured.

Comprehensive, holistic patient care is only possible when a range of services are both available and accessible, and all patients are able to obtain timely care and appropriate advice.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9L.1.1.1							
Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Dental 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 Dental Services are measurable in line with the Facility statements available, endorsed and dated;						
	3. Evidence of planned reviews of the above statements (at least once in 3 years or in the event of any major changes);						
	4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc); and						
	5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.						
CRITERION 9L.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 Dental Services, consultants, medical practitioners and staff of the Dental Services; b) Is accessible to all staff and clients; and c) Is revised when there is a major change in any of the following: i) Organisation; ii) Functions; iii) Reporting relationships; and iv) Staffing patterns.	1. Clearly delineated current organisation chart with line of functions and reporting relationships the Person In Charge (PIC), Head of Dental Services, consultants, medical practitioners and staff of the Dental Services;						
	2. Organisation chart of the service is endorsed, dated and accessible; and						
	3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9L.1.1.3							
The Governing Body shall ensure that the Dental Services are organised in such a way as to: a) Facilitate the provision of Dental 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; and 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.	1. Department/Service operational policies that address;						
	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; and						
	6. Proper and adequate equipment according to current standards.						
CRITERION 9L.1.1.4							
There is a mechanism to ensure effective interaction between the Dental 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:	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; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
a) The appointment of a medical practitioner as the Head of Dental Services delineating his/her authority, responsibilities and accountabilities in a written document according to the relevant Acts to manage and control the Dental Services; and 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 Dental Services	3. Minutes of meetings of MDAC/Management						
CRITERION 9L.1.1.5 (CORE)							
The Head of Dental Services has: a) Representation of the Service in committees and subcommittees where relevant; b) Representation of the Service in clinical staff liaison meetings; and c) Involvement and provide regular input to the Senior Management Team.	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;						
	2. Minutes of meetings of committees; and						
	3. Minutes of meeting of Senior Management Team.						
CRITERION 9L.1.1.6							
The assessment, planning, direction, evaluation and continuity of clinical care are the responsibility of dental	1. Medical Staff By-Laws; clause indicate clinical care responsibility of medical practitioners; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
practitioners managing individual patients, thus ensuring clinical independence.	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 of dental practitioner with MDC number.						
CRITERION 9L.1.1.7							
The Head of Dental 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; and e) Safety and performance improvement activities and risk management.	1. Evidence of (a) to (e) in the minutes of meetings of Dental Services indicate the involvement of Head of Service;						
	2. Endorsement of policies and procedures;						
	3. Request for allocation of budget and staffing; and						
	4. Implementation of performance improvement activities (refer to Quality Improvement activities).						
CRITERION 9L.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 Dental 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 representation of the service;						
	3. Frequency of meetings as scheduled; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	4. Discussion and resolutions are implemented.						
CRITERION 9L.1.1.9							
Where there are dental practitioners in training, there is evidence that: a) Their responsibilities for patient care are documented; b) Their training needs are identified; and c) Appropriate supervision and training are given to the medical practitioners concerned.	1. Structured training programmes for medical practitioners are in place;						
	2. Training timetable, continuing medical education and attendances list;						
	3. Assessment reports; and						
	4. Logbooks						
CRITERION 9L.1.1.10							
Appropriate statistics and records shall be maintained in relation to the provision of Dental Services and used for managing the services and patient care.	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; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	f. Data on performance improvement activities, including performance indicators.						
	2. Clinical records should:						
	a. Be easily retrievable;						
	b. Include x-ray, results of investigation and study models where appropriate;						
	c. Include detailed notes of treatment;						
	d. Be signed, named and dated;						
	e. Include treatment declined or non-compliance;						
	f. Include a copy of all referral letters;						
	g. Pre-procedural preparation by the practitioner administering the sedation (where applicable);						
	h. Pre-operative instructions – refer to Appendix 1 of Protocols for Day Care Anaesthesia;						
	i. Intra-procedural monitoring – efficient record keeping, ensuring comprehensive and accurate information is recorded throughout the procedure until patient is fit for discharge; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	j. Post-operative instructions – refer to Appendix 2 of Protocols for Day Care Anaesthesia						
	3. Where necessary the patient has a written treatment plan, which has been discussed and written consent given.						
CRITERION 9L.1.1.11							
Legal Requirements The clinical practice conforms to relevant statutory regulations. Current Acts and Guidelines are available and accessible to all staff.	1. There is evidence of compliance to the guidelines issued by the regulatory body;						
	2. There is a clear delineation of authority;						
	3. The following documents are available and complied with;						
	a. Infection Control Guidelines;						
	b. Position Statement on the Use of Dental Amalgam;						
	c. Guidelines on Radiation Safety in Dentistry (where applicable);						
	d. Guidelines and Provisions for Public Information;						
	e. Guidelines for Oral Healthcare Practitioners Infected with Blood-borne Viruses;						
	f. Private Healthcare Facilities and Services Act (PHFSA) 1998; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	g. Guidelines for Dental Record Keeping and Dental Charting						
	4. There is a clear delineation of authority.						
CRITERION 9L.1.1.12							
The Head of Services shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	1. Documented and approved BCP for unanticipated situations;						
	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment.						
	3. Clear actions and staff responsibilities during disruption.						

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TOPIC 9L.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD 9L.2.1
CREDENTIALING AND PRIVILEGING
The Dental Services shall be directed by a qualified and competent dental practitioner and staffed by suitably qualified and competent clinical staff to achieve the goals and objectives of the Dental Services.
Appropriate qualification/training is a prerequisite for the delivery of quality patient care. The practice demonstrates support for education and training of staff in order to provide safe and quality patient care.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9L.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; a) 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; b) Competency for each performance is dated, verified and signed by the supervisors;	1. Documented policies and procedures are established to govern the credentialing and privileging processes which include items (a) to (h);						
	1. Compliance with policy and criteria for credentialing and privileging;						
	2. Annual Practising Certificate (APC), Dental Specialist Register certificate and privileging certificate;						
	3. Recommendations from peer/referee;						
	4. Availability of the list of specialised procedures requiring credentialing and privileging; and						
	5. Availability of list of specialised procedures specific to the disciplines performed by Dental Officers; competency records/log						

DISTRIBUTION

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
c) The period of time for which the privileges are to be granted is specified; d) Current registration with the local professional registration bodies, e.g. Malaysian Dental Council, Dental Specialist Register; e) Peer recommendations are taken into account when privileges are being considered; f) The recommendations of the relevant department and/or major professional services for privileges to be granted are taken into consideration; and g) Outcome of privileged procedures must be documented.	books. Credentialing and privileging must be given more weightage – either comply or non-compliance.						
CRITERION 9L.2.1.2 (CORE)							
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; and						
	2. Updated list of staff with privileges conferred is made accessible at point of care.						
CRITERION 9L.2.1.3 (CORE)							
Clinical staff performs within the privileges conferred.	1. Verification of procedures performed by individuals at point of care within the awarded privileging rights with evidence of:						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	a. List of procedures privileged; accessibility of the list be made available at point of care;						
	b. Operating list; and						
	c. Operating notes/clinical notes.						
CRITERION 9L.2.1.4							
The practice has a process for accepting patients for treatment. Urgent cases should be addressed as a priority.	1. Front desk staff able to identify urgent / priority cases; and						
	2. List of conditions defined as urgent is available (the clinic to define based on the services offered).						
CRITERION 9L.2.1.5							
There is evidence of adequate information given to the patients.	1. Adequate information about patient's dental condition is given;						
	a. Information on procedure, possible complication, cost and duration of treatment is given; and						
	b. Appropriate written consent should be taken.						
	2. A dental report is provided to the patient upon request and payment of fees; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	3. The patient is given the opportunity to have a second opinion pertaining to patient's dental condition / treatment.						
CRITERION 9L.2.1.6							
Care provided is respectful of the patient's need for privacy during clinical consultation, examination and procedures.	1. There is evidence that the patient's needs for privacy during examinations and treatment is respected.						
CRITERION 9L.2.1.7							
The Dental Practitioner shall maintain a strictly professional relationship with all patients.	1. Code of Professional Conduct is observed; and						
	2. A chaperon should be present at all times.						
CRITERION 9L.2.1.8							
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;	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; and						
	4. The job description is acknowledged by the staff and signed by the Head of Service and dated.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
iv) Qualifications required and privileges granted; v) Staffing patterns; and vi) Statutory Regulations. e) Administrative and clinical functions.							

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STANDARD 9L.2.2
STAFF TRAINING, EDUCATION, APPRAISAL AND RESEARCH

The Facility and all staff shall demonstrate an ongoing commitment to continuing medical education.
Appropriate qualification/training is a prerequisite for the delivery of quality patient care. The practice demonstrates support for education and training of staff in order to provide safe and quality patient care.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9L.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	1. There is appropriate induction training which should include:					
	a. Infection control procedures;					
	b. Waste disposal;					
	c. Radiation safety (where applicable); and					
	d. Handling of amalgam (where applicable)					
	2. Availability of continuous training					
	a. Evidence of in-house training, e.g. Continuing Professional Development (CPD); and					
	b. There is support for training, self-improvement and professional development.					
	3. Training calendar includes in-house/external courses/ workshop/conferences;					
	4. Contents of training programme;					
	5. Training records on continuing education activities are kept and					

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	maintained for each staff including training in life support; and						
	6. Certificate of attendance/degree/post basic training.						
CRITERION 9L.2.2.2							
The educational needs of staff and the Facility, as evidenced by the results of healthcare evaluation such as incident reports, performance improvement studies and complaints, are taken into consideration when the content and structure of educational activities are planned.	1. Evidence of inclusion of results of audit activities, e.g. mortality and morbidity reviews, incident reporting, etc in educational activities; and						
	2. Evidence of improvement made from corrective or preventive measures from incident reports.						
CRITERION 9L.2.2.3							
In a Facility where undergraduate dental, 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.	1. Sufficient skilled trained staff to provide clinical supervision as per terms of Memorandum of Understanding.						
CRITERION 9L.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	1. Training needs assessment is carried out and gaps identified;						
	2. A staff development plan based on training needs assessment is available;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
in their current positions and future advancement.	3. Training schedule/calendar is in place; and						
	4. Training module						
CRITERION 9L.2.2.5							
Staff including dental practitioners receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.	1. Performance appraisal for staff including dental practitioner is completed upon probationary period and as an annual exercise.						
CRITERION 9L.2.2.6							
Where appropriate the Facility shall endeavour to undertake clinical research using available resources.	1. Documented evidence of research activities e.g. protocol, policies, consent etc.						

STANDARD 9L.2.3
STAFFING LEVEL AND STAFF COMPETENCY
The Head and staff of the Dental Services including medical practitioners are individuals qualified by education, training and experience commensurate with the requirements of the various positions and relevant laws.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9L.2.3.1							
Deployment of all service providers for Dental Services takes the following factors into consideration: a) The number of persons deployed is proportional to	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;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and 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.	b. Special skills/training of staff;						
	c. Contingency plan during acute shortage;						
	d. Duty roster; and						
	e. Evidence that staff and doctors are not made to work more than the limits set by different authorities.						
CRITERION 9L.2.3.2							

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Appropriate and adequate staffing is available.	1. Valid Practising Certificate;						
	2. Number of support staff commensurate with number of practitioners:						
	a. A ratio of at least 1 operator: 1 clinical support staff member;						
	b. A ratio of 1 clinical support staff: 1 dental chair; and						
	c. At least 1 administrative staff member.						
	3. Job descriptions for staff are available. Different categories of staff are identifiable; and						
	4. Staff employment complies with labour laws.						
CRITERION 9L.2.3.3							
Adequate information as to the practice hours is available.	1. Operating hours displayed to be seen from outside the clinic; and						
	2. Information is available to patients to access care out of normal surgery hours.						
CRITERION 9L.2.3.4							
Comprehensive and clear information of the services available which will enable the patients to choose the practice that best meets the patient needs.	1. List of services displayed in clinic;						
	2. Patient information on services / treatments offered.						
CRITERION 9L.2.3.5							
Treatment/services is fair and accessible to all patients.	3. The practice does not discriminate on the grounds of:						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	a. Race, gender, social class, age, religion, sexual orientation or appearance; and						
	b. Disability or medical condition						

STANDARD 9L.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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9L.2.4.1							
There is a structured orientation programme for all newly appointed, contracted and outsourced staff to the Services that include but not limited to the following: **General**	1. Policy requiring all new staff to attend a structured orientation programme; and						
	2. There is a Services orientation programme with relevant topics not limited to topics covered from (a) to (q).						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
a) Vision and mission of the Facility; b) Organisation chart and reporting structure of the Facility; c) Environment and facility safety policies and procedures including sustainability practices; d) Infection control policies and procedures; e) Policies for performance management, patient safety (IPSG/MPSG) and risk management; f) Ethical practices and code of conduct including medicolegal awareness; g) Management of aggression, violence and harassment; and h) Patient and family rights. **Services** i) Goals, objectives and organisational structure of Services; j) Policies and procedures relevant to Services; k) Working instructions for patient care; and l) Service continuity plan for Services in response to internal and external disasters. **Job-specific**	1. Attendance list						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
m) Explanation of particular duties and functions; n) Explanation of the methods of assigning clinical care and the standards of clinical practice; o) Handover communication; p) Training in basic/advanced life support techniques; and q) Technology and equipment use including artificial intelligence, digital care and robotics.							

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STANDARD 9L.2.5 (NEW)

The Dental Services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the surgical related staff, ensuring a safe and healthy work environment.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9L.2.5.1 (CORE)							
The Services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being. a) A health-promoting environment, e.g., stress management, burn out, staff engagement opportunities, workload monitoring, management of work life balance, healthy, lifestyle programmes e.g. Workplace Wellness Programs, Community-Based Health Initiatives; b) Staff shall be provided with appropriate supervision, support, and advice e.g., mentor mentee program; and c) There shall be clear procedures for the effective management of underperformance e.g., feedback on performance review or performance appraisal report.	3. The promotion of staff well-being may involve the following:						
	a. Evidence of a health promoting environment e.g., workplace wellness programme**;**						
	b. Evidence of proper supervision of staff; and						
	c. Evidence of staff appraisal programme with feedback on underperformance.						
CRITERION 9L.2.5.2 (CORE)							
The dental services shall establish a safe mechanism for dental staff to express	4. Dental **s**taff suggestions and grievance reporting and processing mechanisms are available;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety.	5. The resolution of workplace issues may involve the following:						
		a. Measures and evidence of Dental staff protection including whistleblowers against violence, bullying, and harassment e.g., awareness campaigns, anonymous reporting channel, Whistleblower policy; and					
		b. Documented policies and procedures for violence activation and surgical related staff protection.					
CRITERION 9L.2.5.3 (NEW)							
A system shall be created to gather staff feedback about their workplace experience such as burnout which shall be analysed and used to make improvements that enhance the work environment, staff satisfaction, and organisation culture.	1. Staff feedback (e.g., minutes of sessions or staff satisfactions survey)						
		a. Evidence of action or improvement taken.					
CRITERION 9L.2.5.4 (NEW)							
The Dental Services shall track sick leave and staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning	1. Evidence that workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments. The results shall be used to create focused actions that improve staff well-being, solve problems, and help retain employees.						

TOPIC 9L.3
POLICIES AND PROCEDURES

Standard 9L.3.1
DEVELOPMENT, DERIVATION AND DOCUMENTATION

There are written and dated policies and procedures for all activities of the Dental 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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9L.3.1.1 (CORE)							
There are written policies and procedures for the Dental Services which are consistent with the overall policies of the Facility, regulatory requirements, current standard practices and Patients and Family Rights. 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.	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; and						
	4. The policies and procedures are endorsed and dated.						
CRITERION 9L.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	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; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
with reference to relevant sources involved. Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.	3. Cross departmental policies						
CRITERION 9L.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 Dental Services; b) Clinical practice guidelines (where appropriate): i) Management of Hypodontia; ii) Management of Chronic Periodontitis; iii) Management of Periodontal Abscess; iv) Management of Severe Early Childhood Caries; v) Management of Avulsed Permanent Anterior Teeth in Children; vi) Management of Ameloblastoma of the Jaw; vii) Antibiotic Prophylaxis against Wound Infection for Oral Surgical Procedures;	4. Documented policies and procedures that address but not limited to (a) to (n).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
viii) Management of Unerupted Maxillary Incisor; ix) Management of Unilateral Condylar Fracture of the Mandible; x) Management of Unerupted and Impacted Third Molar Tooth; xi) Management of the Palatally Ectopic Canine; and xii) Management of Anterior Crossbite in the Mixed Dentition. c) Clinical documentation includes pain as the 5th vital sign where appropriate; d) Handover communication in timely manner; 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							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
including notification of notifiable diseases; k) The responsibilities of the staff including dental 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) Safe use or lasers devices cross reference to standard 3; n) 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); o) Register of implantable medical devices registered under Medical Device Acts; and p) Compliance to SOPs for the use of loan equipment.							
CRITERION 9L.3.1.4							
Information on fees to be charged is made available to the patient.	1. Fee schedule is available and accessible;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	2. Patient is informed of the details of fees that will be charged, prior to commencement of treatment;						
	3. A receipt is given for every payment and an itemised bill is given to the patient upon request; and						
	4. Adherence to code of conduct.						
CRITERION 9L.3.1.5							
Patient assessment shall be appropriate, comprehensive and documented	1. Appropriate assessment is conducted to support care of the patient;						
	2. Appropriate reassessment of patient is carried out to ensure continuity of care;						
	3. Evidence that service delivery is planned and monitored;						
	4. Patients are reassessed at appropriate intervals;						
	5. Mechanism for incident reporting shall be established, documented and acted upon to prevent recurrences; and						
	6. Repeat no (3).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9L.3.1.6							
Patient health records contain sufficient information to identify the patient OR patient undergoing for treatment under sedation and to document reasons for visit, assessment, management, progress and outcome.	1. The Registered Dental Practitioner maintains a system of creating and updating Dental information on every patient;						
	2. Each patient has an individual health record containing all relevant clinical information;						
	3. There is efficient record keeping, ensuring comprehensive and accurate information is recorded;						
	4. There is a daily record of patients attending the clinic;						
	5. Repeat no.(2); and						
	6. An initial examination should include but is not limited to: a. Medical history; b. Full dental charting; c. Risk habits (including tobacco use); d. Periodontal status; e. Soft tissue examination; and f. Appliances used.						
CRITERION 9L.3.1.7							
Current policies and procedures are communicated to all staff.	1. Training and briefing on the current policies and procedures/Minutes of meetings; and						
	2. Circulation list and acknowledgement.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9L.3.1.8 (CORE)							
There is evidence of compliance with policies and procedures. Policies and procedures are integrated in the care of patients incorporating but not limited to the following: a) Admission process; b) Preprocedure/investigation assessment; c) Intra procedure/ investigation protocols; d) Post procedure/investigation care; e) Transition of care process; f) Prevention & control of infection; g) Environment of care for patients; and h) Discharge process. There is evidence of compliance with policies and procedures on various types of patients.	3. Compliance with policies and procedures through:						
	a) Interview of staff on practices;						
	b) Verify with observation on practices;						
	c) Results of audit on practices; and						
	d) Practices in line with established policies and procedures including current CPGs						
CRITERION 9L.3.1.9							
Copies of current policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.	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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9L.3.1.10							
The services shall operate on a 24-hour basis providing a level of care appropriate to the activities of the patients in the Facility.	1. Operational policy on 24-hour services;						
	2. Staffing level reflects good mix of experienced staff and the intensity of activities during each shift; and						
	3. On-call roster is dated and authorised.						

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TOPIC 9L.4
FACILITIES AND EQUIPMENT

STANDARD 9L.4.1
The Head of Dental 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 Dental Services.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9L.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.	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 trolley, hand washing facilities etc);						
	4. Easy access and clear exit routes; and						
	5. Absence of overcrowding.						
CRITERION 9L.4.1.2							
Existing facilities shall take cognisance of the safety of staff and patients.	6. 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;						

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	7. Adequate equipment and supplies for Dental Services, e.g. infusion pumps, functioning patient call bell, ripple mattress etc; and						
	8. Equipment should have scheduled planned preventive maintenance (PPM).						
CRITERION 9L.4.1.3							
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 (PIC).	1. Appropriate telecommunication modalities available for daily operation and during emergencies;						
	2. Equipment and instrument;						
	a. Sufficient autoclaves, at least 2 available (to allow efficient sterilisation procedures to be followed and to minimise risk of service disruption should one fail);						
	b. All instruments are sterilised;						
	c. Autoclaved instruments are stored in sealed pouches with packing date and expiry date recorded on the pouch; and						
	d. All hand-pieces are sterilised between patients.						
	3. All sharps are disposed directly into clinical waste sharps bin;						
	4. All clinical staff wear personal protective equipment;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	5. Staff education on Infection Control procedures; and						
	6. Records of refresher courses are available.						
CRITERION 9L.4.1.4							
The facility practices appropriate waste management. There shall be a waste and environmental management policy that supports safe practice.	1. Clinical waste management protocol adheres to relevant regulations and guidelines;						
	2. General waste management protocol available;						
	3. Chemical waste management protocol adheres to where appropriate;						
	4. Controls are implemented to cover identification, handling, separation of clinical, chemical, general waste and scheduled waste;						
	5. Waste is managed in accordance with relevant legislation, codes of practice, standards and guidelines;						
	6. Instruments are cleaned of waste amalgam before sterilizing (where applicable); and						
	7. Waste amalgam is collected from amalgam trap in the spittoon and separator at suction unit .						
CRITERION 9L.4.1.5							
The facility provides a safe and healthy environment.	1. Occupational safety and health measures:						
	a. All staff comply with the protocol for management of spillage of blood and other body fluids;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	b. Clinical staff immunised against hepatitis; and						
	c. Hazardous materials are labelled.						
	2. Mercury Hygiene Practice (where applicable):						
	a. Only encapsulated amalgam used;						
	b. Closed non-fragile container used for storage of waste amalgam; and						
	c. Waste amalgam stored dry.						
	3. Radiation Safety (where applicable):						
	a. Warning sign / light during x-ray operation;						
	b. Protective equipment (lead apron with thyroid shield for conventional radiography) is used and in good condition;						
	c. Protective equipment for operator is available and in good condition;						
	d. Precautionary signages for antenatal mother displayed;						
	e. Reports on radiographs are included in clinical notes;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	f. Valid license for X-ray equipment; and						
	g. A quality assurance programme is in place. (e.g. Film rejects rate).						
	4. Floor plan and signages:						
	a. Floor plan with safety equipment and emergency exit indicated; and						
	b. Relevant safety signages displayed.						
	5. Dental Laboratory (where applicable):						
	a. Gas tank placed in a designated safe area;						
	b. Machines used for polishing prosthesis/ appliance have a vacuum system and safety protector;						
	c. Material and equipment for disinfection process available;						
	d. Fume cupboard is available where acrylic work is carried out; and						
	e. Laboratory staff wear appropriate personal protective equipment during laboratory work.						
	6. Disaster management system in place.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9L.4.1.6							
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	1. Appropriate telecommunication modalities available for daily operation and during emergencies.						
CRITERION 9L.4.1.7							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care.						

STANDARD 9L.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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9L.4.2.1							
Facilities are suitably located to facilitate easy access and to provide an atmosphere of user, environmental and 'disabled' friendly.	1. Floor plan indicates accessibility and patient and user friendly;						
	2. Feedback from patient satisfaction survey; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	3. Incident reporting relating to facilities if any.						
CRITERION 9L.4.2.2							
The practice conforms to all structures and physical requirements appropriate to the level of services under the relevant statutory regulations.	1. There is valid registration of the practice with the relevant authority;						
	2. The physical structure of the clinic shall comply with all relevant regulatory requirements; and						
	3. Dental X-ray Room/ Area:						
	a. Physical structure compliant.						
CRITERION 9L.4.2.3							
Equipment, both for emergency and non-emergency usage, shall be appropriate to the level of care.	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; and						
	2. Scheduled checking of items in emergency trolley.						
CRITERION 9L.4.2.4							
All equipment for the provision of the level of services shall be adequate, appropriate and well maintained.	1. There is evidence of compliance where appropriate to:						
	a. Certification;						
	b. Scheduled maintenance; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	c. Calibration.						
	2. Planned preventive maintenance:						
	a. Evidence of Programme for maintenance and calibration of equipment and facility available [OSHA, Sec 15(2)(a)] Report/test/QA certificate available for:						
	i. Imaging equipment;						
	ii. Autoclave; and						
	iii. Compressor.						
	3. Where specialised equipment;						
	a. Ensure appropriately qualified staff operates such equipment;						
	b. When laser equipment is used, warning sign is displayed outside the operating room; and						
	c. When inhalation sedation is used, scavenging system is available.						
CRITERION 9L.4.2.5							
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); and						
	2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	Malaysia (SIRIM), etc as evidence of compliance to the relevant standards and Acts.						
CRITERION 9L.4.2.6 (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.	1. Planned Preventive Maintenance records such as schedule, stickers, etc;						
	2. Planned Replacement Programme where applicable;						
	3. Complaint records; and						
	4. Asset inventory.						
CRITERION 9L.4.2.7							
Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.	1. User training records;						
	2. Competency assessment record;						
	3. Letter of authorisation; and						
	4. List of staff trained and authorised to operate specialised equipment, example:						
	a. Imaging equipment;						
	b. Laser equipment;						
	c. Autoclaves; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	d. Other related equipment as appropriate.						
CRITERION 9L.4.2.8							
Equipment is upgraded (based on evidence) from time to time so as to keep pace with advancement in operative and diagnostic techniques and technology.	1. Equipment are being replaced and upgraded to meet current standard of care and advancement in technology in a planned and systematic manner.						

STANDARD 9L.4.3
FACILITIES FOR SURGICAL 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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9L.4.3.1							
There is an appointment system available in the practice which is designed to minimise waiting time	1. A patient appointment system is practiced based on treatment needs;						
	2. There is an appointment system; and						
	3. The duration of appointments is based on treatment procedures.						

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TOPIC 9L.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 9L.5.1
The Head of Dental Services shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Dental Services. The Head of Dental Services shall ensure compliance to monitoring of specific performance indicators.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9L.5.1.1							
There are periodical planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Dental 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; and g) Innovation	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; and						
	6. Records on innovation if available.						
CRITERION 9L.5.1.2							
The Head of Dental Services has assigned the responsibilities for planning, monitoring and managing safety and	1. Minutes of Meetings;						
	2. Letter of assignment of responsibilities; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
performance improvement activities to appropriate individual/ personnel within the respective services.	3. Term of Reference						
CRITERION 9L.5.1.3							
The Head of Dental 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.	1. System for incident reporting is in place, which include:						
	a. Training of staff;						
	b. Policy on incident reporting;						
	c. Methodology of incident reporting; and						
	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;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	7. Acknowledgment by Head of Service and PIC/Hospital Director; and						
	8. Feedback given to staff regarding incident reporting.						
CRITERION 9L.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 medical practitioners undertake clinical reviews of	1. Performance improvement activities;						
	2. Minutes of Meetings; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and 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.	3. Relevant reports and documents, e.g. clinical audit reports, incident reports, mortality and morbidity review reports, etc.						
CRITERION 9L.5.1.5 (CORE)							
The quality improvement activities include evaluation of clinical and non-clinical services.	1. Adequate records are maintained about quality improvement activities;						
	2. An appropriate complaint mechanism is available;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	3. There is an identified member of the staff to lead in quality improvement activities in the practice;						
	4. Evidence of quality improvement initiatives;						
	5. There shall be a formal method of feedback on the facility and services from the patient and staff (e.g. suggestion box);						
	6. Evidence that suggestions from feedback are considered and implemented where appropriate; and						
	7. A grievance mechanism shall be in place.						
CRITERION 9L.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 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	1. Specific performance indicators monitored;						
	2. Records on tracking and trending analysis;						
	3. Minutes of mortality/morbidity audits meetings; and						
	4. Remedial measures taken where appropriate.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
same hospital admission following surgery d) Waiting time according to Client Charter e) Completion of medical report within 14 days Specialty units in the Dental Services (e.g. OMF, Paeds Dentistry, OMOP, Special Care Dentistry, Forensic Odontology), shall monitor any other two (2) indicators to support its goals and objectives.							
CRITERION 9C.5.1.7 (NEW)							
The Services participates in the Facility's safety culture assessment. The results are utilized by Service leadership to inform and guide efforts to improve the culture of safety within the Service.	1. Safety Culture Survey for staff						
CRITERION 9L.5.1.8							
Feedback on results of safety and performance improvement activities are regularly communicated to the staff to promote transparency, shared learning, and active engagement in improvement initiatives.	1. Results on safety and performance improvement activities are accessible to staff through education sessions, meetings and digital communications.						
CRITERION 9L.5.1.9							
Appropriate documentation of safety and performance improvement activities is kept and confidentiality of dental	1. Documentation on performance improvement activities and performance indicators; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
practitioners, staff and patients is preserved.	2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						

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TOPIC 9L.6
SPECIAL REQUIREMENTS

SEDATION IN DENTAL PRACTICE
Sedation during dental procedures is no longer uncommon. When it is used judiciously, sedation can be a useful adjunct to many dental procedures.

When performed by non-anaesthesiologists, the level of sedation should be kept at mild to moderate. Deep sedation should be avoided unless an anaesthesiologist or a physician with expertise in airway management is present throughout the procedure.

STANDARD 9L.6.1
CLINICAL GOVERNANCE FOR SEDATION

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9L.6.1.1							
The clinical practice conforms to relevant recommendations and guidelines. Current documents are available and accessible to all staff.	1. There is evidence of compliance to the guidelines issued by the regulatory body;						
	2. The following documents are available and complied with:						
	a. Recommendations for Sedation and Analgesia by Non- Anaesthesiologists;						
	b. Protocols for Day-care Anaesthesia; and						
	c. Guidelines for Conscious Sedation in Dentistry for Adult Patients.						

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STANDARD 9L.6.2
HUMAN RESOURCE
Appropriate qualifications/training is a prerequisite for the delivery of quality patient care. The practice ensures that suitably qualified staff are employed for the level of services offered and demonstrates support for education and training of staff in order to provide safe and high quality patient care.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9L.6.2.1							
Personnel with relevant training is available.	1. The practitioner administrating oral or inhalation sedation must have appropriate training and be certified in Basic Life Support (BLS);						
	2. The practitioner administering intravenous sedation must have recognised training in intravenous sedation and be certified in Basic Life Support (BLS);						
	3. Proof of training in administration of oral or inhalation sedation;						
	4. Valid BLS certificate; and						
	5. Proof of training in IV sedation.						

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STANDARD 9L.6.3
POLICY FOR SEDATION
The aims of procedural sedation and/or analgesia are to enhance patient comfort whilst facilitating completion of the planned procedure.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9L.6.3.1							
The practice must declare their services regarding sedation.	1. Practice policies are available;						
	2. Documentation on practice policies regarding sedation and anaesthesia is available, and includes the following:						
	a. Patient must be accompanied by a responsible adult; and						
	b. The patient has to remain in the facility for a reasonable duration post- sedation.						
	3. Patients received written pre and post-operative advice for surgical procedures and procedures carried out under conscious sedation;						
	4. Comprehensive documentation:						
	a. Diagnosis;						
	b. Procedure to be performed;						
	c. Consent;						
	d. Pre-op and post-op information for sedation;						
	e. Intraoperative monitoring of sedation; and						
	f. Criteria for discharge.						

STANDARD 9L.6.4
FACILITIES FOR WITH INTRAVENOUS (IV) SEDATION

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 9L.6.4.1							
The practice conforms to all structures and physical requirements appropriate to the level of services under the relevant statutory regulations.	1. There is valid registration of the practice with the relevant authority;						
	2. The physical structure of the clinic shall comply with all relevant regulatory requirements;						
	3. Electrical source:						
	a. Sufficient and appropriately placed power outlets; and						
	b. Power backup is available in case of disruption in electric supply.						
	4. Sedation room and/cum recovery bay: The procedure must be performed in a room that is of adequate size, and is equipped to deal with a cardiopulmonary emergency.						
CRITERION 9L.6.4.2							
All equipment for the provision of the level of services shall be adequate, appropriate and well maintained. a) Availability; and b) Planned preventive maintenance.	1. The appropriate equipment is available in the facility, based on the level of sedation practised;						
	2. These equipments shall be available:						
	a. A pulse oximeter;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	b. A sphygmomanometer or other blood pressure monitoring device;						
	c. A supply of oxygen and suitable devices for administration of oxygen to a spontaneously breathing patient;						
	d. An Automatic External Defibrillator (AED) is available (compulsory for IV sedation);						
	e. Ready access to an ECG;						
	f. Availability of resuscitation trolley with appropriate drugs and equipment for cardiopulmonary resuscitation:						
	i. Instruments in the Resuscitation Trolley must include the following for IV and oral sedation:						
	A. Syringes and needles of various sizes;						
	B. Intravenous cannula of various sizes;						
	C. IV administration sets;						
	D. Oropharyngeal airways, nasopharyngeal airways of various sizes;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	E. Laryngoscopes and blades of various sizes;						
	F. Endotracheal tubes of various sizes;						
	G. Self-inflating bags with face masks (e.g. Ambu bag);						
	H. Oxygen supply and means of delivery via flowmeters;						
	I. Suction equipment;						
	J. Pulse oximeter, Non-invasive blood pressure monitor (NIBP), ECG; and						
	K. Defibrillator.						
	ii. The drugs in the Resuscitation Trolley must include the following for IV and oral sedation:						
	A. Adrenaline;						
	B. Atropine;						
	C. Frusemide;						
	D. Lignocaine;						
	E. Sodium Bicarbonate 8.4%;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	F. Calcium chloride;						
	G. Nitroglycerine;						
	H. Naloxone;						
	I. Flumazenil; and						
	J. Hydrocortisone						
	g. A means of summoning emergency assistance;						
	h. Planned preventive maintenance Evidence of scheduled maintenance and calibration of equipment and appliances [OHSA, Sec 15(2)(a)];						
	i. Where specialised equipment is used:						
	i. Ensure appropriately qualified staff operate such equipment.						
	3. There is evidence of compliance where appropriate to:						
	a. Certification;						
	b. Scheduled maintenance; and						
	c. Calibration.						

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SERVICE SUMMARY	
OVERALL RATING :	
OVERALL RISK :	

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SERVICE STANDARD 10: ANAESTHETIC SERVICES

PREAMBLE

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.

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:

a) Pain Management Units:
- ***i) Acute Pain Service (APS);***
- ***ii) Chronic Pain Clinics; and***
- ***iii) Obstetric analgesia service.***

b) Anaesthetic clinics for preoperative assessment of patients scheduled for surgery/ procedure requiring anaesthesia.

TOPIC 10.1
ORGANISATION AND MANAGEMENT

STANDARD 10.1.1
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.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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	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 are measurable in line with the Facility statements are						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.	available, endorsed and dated;						
	3. Evidence of planned reviews of the above statements (at least once in 3 years or in the event of any major changes);						
	4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc); and						
	5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.						
CRITERION 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; and d) Is revised when there is a major change in any of the following: i) Organisation; ii) Functions; iii) Reporting relationships; iv) Staffing patterns	1. Clearly delineated current organisation chart with line of functions and reporting relationships the Person In Charge (PIC), Head of Anaesthetic Services, relevant medical subspecialties services/units, consultants, anaesthetic practitioners and staff of the Anaesthetic Services;						
	2. Organisation chart of the services endorsed, dated and accessible; and						
	3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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	1. Minutes are accessible, disseminated and acknowledged by the staff;						
	2. Attendance list of members with adequate representation of the service;						
	3. Frequency of meetings as scheduled; and						
	4. Discussion and resolutions are implemented.						
CRITERION 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.	1. Minutes of Facility-wide management meeting;						
	2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service; and						
	3. Approved budget and resources.						
CRITERION 10.1.1.5							
The Head of Anaesthetic Services is involved in the appointment and/OR assignment of staff.	1. Records on staff interview (if applicable);						
	2. Appointment/assignment letter of Head of Service;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	3. Job description of Head of Service;						
	4. Records on staff deployment; and						
	5. Duty roster.						
CRITERION 10.1.1.6							
The Anaesthetic Services has: a) Representation of the service in the Operating Theatre Committee; and b) Representation of the service in committee and subcommittee where relevance.	1. Appointment letter of Head of Service in the Committee;						
	2. Terms of Reference; and						
	3. Minutes of Committee meetings.						
CRITERION 10.1.1.7							
The Anaesthetic Services support and maintain responsibility for general intensive care services of the Facility	1. List of services provided to other Units in the Facility by the Anaesthetic Services; and						
	2. Documented responsibility for General Intensive Care Services.						
CRITERION 10.1.1.8							
	1. Documented responsibility for safe anaesthetic services to obstetric patients.						
CRITERION 10.1.1.9							
Appropriate statistics and records shall be maintained in relation to the	1. Records are available but not limited to the following:						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
provision of Anaesthetic Services and used for managing the services and patient care.	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; and						
	g. Data on performance improvement activities, including performance indicators.						
CRITERION 10.1.1.10							
The Head of Services shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical	1. Documented and approved BCP for unanticipated situations;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment.						
	3. Clear actions and staff responsibilities during disruption;						
	4. Record of drills or tests, with follow-up actions, if conducted; and						
	5. Review of Risk Register.						

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TOPIC 10.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD 10.2.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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; and						
	4. Training and competency records.						
CRITERION 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	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;					

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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	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; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
emergency anaesthetic services; 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; and 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.	h. Minutes of meetings with other representatives in relation to policies and performance improvement initiatives.						
CRITERION 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.	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; and						
	5. Census and statistics.						
CRITERION 10.2.1.4							

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
There are written and dated specific job descriptions for all categories of staff that include: qualification, training, experience and certification required for the position; a) Qualifications, training, experience and certification required for the position; b) Lines of authority; c) Accountability, functions, and responsibilities; and 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; and vi) Statutory Regulations e) Administrative and clinical functions.	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;						
	4. Relevant privileges granted where applicable; and						
	5. The job description is acknowledged by the staff and signed by the Head of Service and dated.						
CRITERION 10.2.1.5							
Personnel records on training, staff development, leave including sick leaves and others are maintained for every staff. **Note:**	1. Staff personal records include:						
	a. Staff biodata;						
	b. Qualification and experience;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Staff personal record may be kept in Human Resource Department as per Facility policy	c. Evidence of current registration;						
	d. Training record;						
	e. Competency record and privileging;						
	f. Leave record; and						
	g. Confidentiality agreement.						
CRITERION 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	1. National Specialist Register (NSR) certificates for Anaesthetists;						
	2. Assignment of medical practitioners in the Anaesthetic Services address (a) to (e);						
	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; and						
	7. Documented evidence and verification of assignment of one anaesthetist to one patient at any one time of surgery.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
from performing anaesthesia on a fulltime basis; 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; and e) Anaesthetic services shall be available 24 hours per day, as required by the Facility's scope of services through an on call roster.							
CRITERION 10.2.1.7							
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.	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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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	5. Logbook for procedures performed; and						
	6. Privileging of Specialist and Medical Officer.						
CRITERION 10.2.1.8							
There are continuing education activities for staff including medical practitioners to pursue professional interests and to prepare for current and future changes in practice.	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); and						
	4. Certificate of attendance/degree/post basic training.						
CRITERION 10.2.1.9							
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.	1. Records on continuing professional education activities for staff;						
	2. Training records for degree or post-graduate training programmes; and						
	3. Certificate of attendance at conferences.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 10.2.1.10							
Th 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.	1. Performance appraisal for staff including medical practitioners is completed upon probationary period and as an annual exercise.						
CRITERION 10.2.1.11							
In facilities where trainee specialists, houseman and medical undergraduates are present, provision is made for their adequate training.	1. Sufficient skilled trained staff to provide clinical supervision as per terms of Memorandum of Understanding;						
	2. Logbooks;						
	3. Assessment reports; and						
	4. Training timetable, continuing medical education and attendance list.						

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STANDARD 10.2.2
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.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 10.2.2.1							
There is a structured orientation programme for all newly appointed, contracted and outsourced staff to the Anaesthetic Services including medical practitioners and for those new to specific areas that include but not limited to the following: <u>General</u> a) Vision and mission of the Facility; b) Organisation chart and reporting structure of the Facility; c) Environment and facility safety policies and procedures including sustainability practices; d) Infection control policies and procedures; e) Policies for performance management, patient safety (IPSG/MPSG) and risk management; f) Ethical practices and code of conduct including medicolegal awareness;	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 (q); and						
	3. Attendance list.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
g) Management of aggression, violence and harassment; and h) Patient and family rights. <u>Services</u> i) Goals, objectives and organisational structure of Anaesthetic Services; j) Policies and procedures relevant to Anaesthetic Services; k) Working instructions for patient care; and l) Service continuity plan for Anaesthetic Services in response to internal and external disasters <u>Job-specific</u> m) Explanation of particular duties and functions; n) Explanation of the methods of assigning clinical care and the standards of clinical practice; o) Handover communication; p) Training in basic/advanced life support techniques; and q) Technology and equipment use including artificial intelligence, digital care and robotics.							

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STANDARD 10.2.3 (NEW)

The anaesthetic services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the anaesthetic staff, ensuring a safe and healthy work environment.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 10.2.3.1 (CORE)							
The anaesthetic services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being. a) A health-promoting environment, e.g., stress management, burn out, staff engagement opportunities, workload monitoring, management of work life balance, healthy, lifestyle programmes e.g. Workplace Wellness Programs, Community-Based Health Initiatives; b) Staff shall be provided with appropriate supervision, support, and advice e.g., mentor mentee program; and c) There shall be clear procedures for the effective management of underperformance e.g., feedback on performance review or performance appraisal report.	1. The promotion of staff well-being may involve the following:						
		a. Evidence of a health promoting environment e.g., workplace wellness programme;					
		b. Evidence of proper supervision of staff; and					
		c. Evidence of staff appraisal programme with feedback on underperformance.					
CRITERION 10.2.3.2 (CORE)							
The anaesthetic services shall establish a safe mechanism for anaesthetic staff to express	1. Anaesthetic staff suggestions and grievance reporting and processing mechanisms are available;						

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RITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety.	2. The resolution of workplace issues may involve the following:						
	a. Measures and evidence of anaesthetic staff protection including whistleblowers against violence, bullying, and harassment e.g., awareness campaigns, anonymous reporting channel, Whistleblower policy; and						
	b. Documented policies and procedures for violence activation and anaesthetic staff protection.						
CRITERION 10.2.3.3 (NEW)							
A system shall be created to gather staff feedback about their workplace experience, such as burnout, which shall be analysed and used to make improvements that enhance the work environment, anaesthetic staff satisfaction, and organisation culture.	1. Anaesthetic staff feedback (e.g., minutes of sessions or anaesthetic staff satisfactions survey):						
	a. Evidence of action or improvement taken.						
CRITERION 10.2.3.4 (NEW)							
The anaesthetic services shall track sick leave and anaesthetic turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning.	1. Evidence that workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments. The results shall be used to create focused actions that improve anaesthetic staff well-being, solve problems, and help retain anaesthetic employees						

TOPIC 10.3
POLICIES AND PROCEDURES

STANDARD 10.3.1
DEVELOPMENT, DERIVATION AND DOCUMENTATION
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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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, current standard practices and Patients and Family Rights. 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.	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; and						
	4. The policies and procedures are endorsed and dated.						
CRITERION 10.3.1.2 (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	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; and						
	3. Documented cross departmental policies.						

DISTRIBUTION

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
policies and procedures where applicable.							
CRITERION 10.3.1.3 (CORE)							
Policies and procedures on Anaesthetic Services shall include the; 1. Anaesthetic care shall comply with the College of Anaesthesia Guidelines or equivalent; and 2. 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.	3. 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. An SOP for difficult intubation management shall be available, outlining decision-making based on patient condition, trained personnel availability, and equipment readiness;						
	h. Guidelines for the management of obese patient coming for surgery (2015);						
	i. The presence of a dedicated anaesthetist/privileged medical practitioner who is solely responsible for the care of the patient per operation;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	j. Rostering of manpower distribution in the operating room; and						
	k. Recommendations for Patient Safety and Minimal Monitoring Standards during Anaesthesia and Recovery (2013).						
CRITERION 10.3.1.4							
There are written guidelines or protocol for patients undergoing all anaesthetic and sedation procedures	1. Documented guidelines/protocols for patients undergoing anaesthetic and sedation procedures.						
CRITERION 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.	1. Policy for consent taking; and						
	2. Anaesthetic consent form developed in accordance with the Malaysian Medical Council guidelines.						
CRITERION 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.	1. Verification of evidence of pre-operative assessment by anaesthetist in patient's medical records or Anaesthetic forms.						
CRITERION 10.3.1.7							
All anaesthetic procedures shall comply with standard infection control guidelines to prevent	1. Guidelines on infection control policy in the operating theatre are available and adhered to;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
cross infection between patients. Breathing apparatus shall not be shared and disposable items shall not be reused	2. Reusable anaesthetic items and equipment are sterilised according to infection control guidelines; and						
	3. Single use anaesthetic items are disposed after each use.						
CRITERION 10.3.1.8							
Current policies and procedures are communicated and made accessible to all staff.	1. Training and briefing on the current policies and procedures/Minutes of meetings						
	2. Circulation list and acknowledgement						
CRITERION 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	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;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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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.	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;						
	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						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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	Management Handbook (Ministry of Health, current edition)						
CRITERION 10.3.1.10							
There is evidence of compliance with policies and procedures.	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						
CRITERION 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).	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference						
CRITERION 10.3.1.12 (CORE)							
Policies and procedures are integrated in the care of patients incorporating but not limited to the following: d) Admission process;	1. Compliance with policies and procedures through:						
	a. Interview of staff on practices;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
e) Preoperative assessment ; f) Intraoperative protocols; g) Post-anaesthesia care; h) Transition of care process; i) Surgical site infection prevention; j) Day of surgery admission protocols; k) Environment of care for surgical patients; and l) Discharge process. There is evidence of compliance with policies and procedures on various types of patients.	b. Verify with observation on practices;						
	c. Results of audit on practices;						
	d. Practices in line with established policies and procedures.						

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TOPIC 10.4
FACILITIES AND EQUIPMENT

STANDARD 10.4.1
The facilities and equipment in any designated area where anaesthesia is administered are adequate and appropriate for the safe delivery of anaesthesia and resuscitation.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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); and						
	4. Easy access and clear exit routes.						
CRITERION 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	1. Performance of regional blocks is done in areas with proper monitoring and resuscitation facilities						
CRITERION 10.4.1.3							

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Areas where anaesthesia is administered comply with Medical Gas System requirements and standards set by relevant authorities.	1. Presence of gas panel with auditory and visual alarms in the operating room; and						
	2. The alarm system is checked regularly by trained personnel and documented.						
CRITERION 10.4.1.4 (CORE)							
Facilities including emergency equipment and drugs shall be readily available in operating rooms and recovery areas for resuscitation purposes.	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; and						
	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.						
CRITERION 10.4.1.5 (CORE)							
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	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; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.	3. Adequate number of nurses according to norms and suitably qualified and trained to assist in anaesthetic emergencies.						
CRITERION 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.	1. Documented evidence of maintenance records on all equipment used in the delivery of anaesthesia; and						
	2. System on respond to breakdown repair.						
CRITERION 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.	1. Compliance to standard guidelines on monitoring of anaesthetised patients, i.e. “Safety Standards for Anaesthesia and Recovery.						
CRITERION 10.4.1.8							
Anaesthetic delivery systems shall have safety features to prevent accidental hypoxia or disconnection of breathing	1. Availability of general anaesthesia (GA) machines with the required safety features.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
circuits during mechanical ventilation. These will include anti-hypoxic devices, gas module, alarms for oxygen pressure failure, and ventilator disconnect alarms.							
CRITERION 10.4.1.9							
Anaesthetic waste gases and vapours shall be scavenged.	1. Evidence of functional Anaesthetic Gas Scavenging Systems.						
CRITERION 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.	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; and						
	4. Compliance to Safe Surgery Saves Lives checklist.						
CRITERION 10.4.1.11 (CORE)							
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); and						
	2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as evidence						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	of compliance to the relevant standards and Acts.						
CRITERION 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.	1. Electrical installation and supply and electrically operated equipment comply with relevant standards.						
CRITERION 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.	1. Emergency power and suction outlets comply with established standards						
	2. Availability of UPS power supply						
CRITERION 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.	1. Availability of emergency alert.						
CRITERION 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.	1. Planned Preventive Maintenance records such as schedule, stickers, etc.						
	2. Planned Replacement Programme where applicable.						
	3. Complaint records. and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	4. Asset inventory.						
CRITERION 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.	1. Sufficient warming devices available.						
CRITERION 10.4.1.17							
There shall be facilities for rapid transfusion of fluids/blood in patients who have massive haemorrhage.	1. Availability of facilities for rapid transfusion of blood/fluids.						
CRITERION 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.	1. User training records;						
	2. Competency assessment record;						
	3. Letter of authorisation; and						
	4. List of staff trained and competent to operate specialised equipment.						
CRITERION 10.4.1.19							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care.						

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TOPIC 10.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

Standard 10.5.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 10.5.1.1							
There are periodical planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Anaesthetic Services. 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; and g) Innovation.	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; and						
	6. Records on innovation if available.						
CRITERION 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.	1. Minutes of Meetings;						
	2. Letter of assignment of responsibilities; and						
	3. Job description.						
CRITERION 10.5.1.3							
The Head of Anaesthetic Services shall ensure that the staff are	1. System for incident reporting is in place, which include:						

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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.	a. Training of staff;						
	b. Policy on incident reporting;						
	c. Methodology of incident reporting;						
	d. Register/records of incidents; and						
	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; and						
	8. Feedback given to staff regarding incident reporting.						
CRITERION 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	1. Specific performance indicators monitored;						
	2. Records on tracking and trending analysis;						

discharge and one other performance indicator: a) Mandatory indicator: 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; and f) Percentage of cancellation of elective cases after being passed in the anaesthetic clinic (Target: less than 10%). Subspecialties units in the Anaesthetic Services 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. .	3. Remedial measures taken where appropriate; and 4. Mechanism for monitoring prolonged motor blockade due to regional anaesthesia should be in place (Bromage Scoring).						
CRITERION 10.5.1.5 (NEW)							
The Services participates in the Facility's safety culture	1. Safety Culture Survey for staff.						

assessment. The results are utilized by Service leadership to inform and guide efforts to improve the culture of safety within the Service.							
CRITERION 10.5.1.6							
Feedback on results of safety and performance improvement activities are regularly communicated to the staff to promote transparency, shared learning, and active engagement in improvement initiatives.	1. Results on safety and performance improvement activities are accessible to staff through education sessions, meetings and digital communications.						
CRITERION 10.5.1.7							
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.	1. Evidence of mortality and morbidity review and relevant critical incidents presentation with remedial actions formulated and implemented.						
CRITERION 10.5.1.8							
Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.	1. Documentation on performance improvement activities and performance indicators; and						
	2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						

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TOPIC 10.6
SPECIAL REQUIREMENTS

STANDARD 10.6.1
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.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Where these services are available there must be written policies and protocols, adequate manpower and equipment. (Refer Pain Management Handbook 2nd 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; and						
	4. Where a multidisciplinary approach for pre-operative patient assessment is indicated, there is a policy and facility for this service.						
CRITERION 10.6.1.2							
Organisations to protect the health and safety of the workforce while carrying out their duties.	1. Evidence of vaccination for staffs;						
	2. Occupational hazards eg needle stick injury, lifting heavy patients; and						

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	3. PPE while handling infectious disease, handling chemical hazards and disinfectants.						
CRITERION 10.6.1.3							
The standards require organisations to monitor and evaluate the use of AI systems eg., TIVA, EEG, monitoring device to deliver safe, high-quality care, with mitigation of any unintended consequences.	1. Understanding of the application of artificial intelligence in clinical anaesthesia; and						
	2. Anaesthetic practice areas are aligned with safety and security measures concerning artificial intelligence.						

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SERVICE SUMMARY	
OVERALL RATING :	-
OVERALL RISK :	-

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SERVICE STANDARD 11 : OPERATING SUITE SERVICES

PREAMBLE

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.

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.
The operating suite promotes a culture of safe and evidence based practice that is monitored to meet:

a) Expectations of patients;
b) Compliance with regulatory and statutory requirements; and
c) WHO Patient Safety Solutions - Safe Surgery Saves Lives

TOPIC 11.1
ORGANISATION AND MANAGEMENT

STANDARD 11.1.1

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.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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	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 are measurable in line with the Facility statements available, endorsed and dated;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.	3. Evidence of planned reviews of the above statements (at least once in 3 years or in the event of any major changes);						
	4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc); and						
	5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.						
CRITERION 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; and 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 Operating Suite Services, consultants, medical practitioners and staff of the Operating Suite Services;						
	2. Organisation chart of the service is endorsed, dated and accessible;						
	3. The organisation chart shall incorporate off-site Operating Suite Services offered by the facility; and						
	4. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Minutes are accessible, disseminated and acknowledged by the staff.						
	2. Attendance list of members with adequate representation of the service;						
	3. Frequency of meetings as scheduled; and						
	4. Discussion and resolutions are implemented.						
CRITERION 11.1.1.4							
The Operating Suite Services shall be guided lead by an Operating Theatre (OT) Committee (a subcommittee of MDAC) which consists of multidisciplinary users and providers of services.	1. Letters of appointment for the Chairman and members of the Operating Theatre Committee; and						
	2. Terms of Reference.						
CRITERION 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.	1. List of Interdepartmental Committees where OT staff representation is evidenced; and						
	2. Minutes of Interdepartmental Committee meetings on issues related to the provision of operating suite services.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Minutes of management meeting;						
	2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service; and						
	3. Approved budget and resources.						
CRITERION 11.1.1.7							
The Head of Operating Suite Services is involved in the appointment and/OR assignment of staff.	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; and						
	5. Duty roster.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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.						
CRITERION 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; and 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	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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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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.	e. Documentation on disposal of dangerous drugs as per Dangerous Drug Act (DDA) disposal guidelines; and						
	f. Patient medical records on details of procedure and surgeon/personnel involved.						
CRITERION 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.	1. Swab count record in patient medical records.						
CRITERION 11.1.1.11							
Support services such as radiology, pathology, and blood bank are available. Effective communication and relationships with these services are maintained.	1. Cross departmental policies with related support services, i.e. blood bank; and						
	2. Evidence of compliance to such policies as observed on-site.						
CRITERION 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.	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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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	e. Staff training records; and						
	f. Data on performance improvement activities, including performance indicators.						
CRITERION 11.1.1.13							
The Head of Services shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	1. Documented and approved BCP for unanticipated situations;						
	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment.						
	3. Clear actions and staff responsibilities during disruption;						
	4. Record of drills or tests, with follow-up actions, if conducted; and						
	5. Review of Risk Register.						

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TOPIC 11.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD 11.2.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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	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; and						
	3. Training and competency records.						
CRITERION 11.2.1.2							
The authority, responsibilities and accountabilities of the Head of Operating Suite Services are clearly delineated and documented.	1. Appointment/assignment letter for Head of Service; and						
	2. Description of duties and responsibilities.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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CRITERION 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.	1. Letter of appointment and credentials of Operating Suite Services Nurse Manager/Sister.						
CRITERION 11.2.1.4							
Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the need of the services in accordance to the regulatory and requirements	1. Number of staff and qualification should be 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; and						
	4. Census and statistics.						
CRITERION 11.2.1.5							
There are written and dated specific job descriptions for all categories of staff that include:	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;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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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.	2. Job description includes specialisation skills;						
	3. Relevant privileges granted where applicable;						
	4. The nature and scope of work of each staff is specified; and						
	5. The job description is acknowledged by the staff and signed by the Head of Service and dated.						
CRITERION 11.2.1.6							
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.*	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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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	f. Leave record; and						
	g. Confidentiality agreement.						
CRITERION 11.2.1.7							
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.	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; and						
	4. Training module.						
CRITERION 11.2.1.8							
There are continuing education activities for staff including medical practitioners to pursue professional interests and to prepare for current and future changes in practice. Such programmes shall include but not limited to the following: a) New surgical, anaesthetic, and operating suite procedures;	1. Training calendar includes in-house/external courses/ workshop/conferences;						
	2. Contents of training programme;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
b) Regular fire and evacuation drills; c) Basic Life Support (BLS) and Advanced Life Support training; d) The use of new equipment in surgical operations and its maintenance and calibration; and e) Prevention and control of infection.	3. Training records on continuing education activities are kept and maintained for each staff including training in life support; and						
	4. Certificate of attendance/degree/post basic training.						
CRITERION 11.2.1.9							
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.	1. Records on continuing professional education activities for staff;						
	2. Training records for degree or post-graduate training programmes; and						
	3. Certificate of attendance or CPD points at conferences.						
CRITERION 11.2.1.10							
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.	1. Performance appraisal for staff including medical practitioners is completed upon probationary period and as an annual exercise.						
CRITERION 11.2.1.11							
In a teaching facility and recognised training facility, the Operating Suite Services shall provide educational needs and	1. Memorandum of Understanding (MOU);						
	2. Compliance with the Terms of MOU;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
teaching for undergraduates and postgraduates without compromising patient safety and comfort.	3. Ratio of supervisor to students;						
	4. Logbooks;						
	5. Assessment reports; and						
	6. Training timetable, continuing medical education and attendances list.						
CRITERION 11.2.1.12							
Where Facility has responsibilities in teaching and research, the staff cooperate and participate in these programmes as required.	1. Attendance list at teaching workshops; and						
	2. List of research papers.						

STANDARD 11.2.2
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.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 11.2.2.1							
There is a structured orientation programme for all newly appointed, contracted and outsourced staff to the Services that include but not limited to the following: <u>General</u> f) Vision and mission of the Facility	1. Policy requiring all new staff to attend a structured orientation programme;						
	2. There is Services orientation programme with relevant topics not limited to topics covered from (a) to (q); and						
	3. Attendance list.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
g) Organisation chart and reporting structure of the Facility h) Environment and facility safety policies and procedures including sustainability practices i) Infection control policies and procedures j) Policies for performance management, patient safety (IPSG/MPSG) and risk management k) Ethical practices and code of conduct including medicolegal awareness l) Management of aggression, violence and harassment m) Patient and family rights <u>Services</u> n) Goals, objectives and organisational structure of Services o) Policies and procedures relevant to Services p) Working instructions for patient care q) Service continuity plan for Services in response to internal and external disasters <u>Job-specific</u> r) Explanation of particular duties and functions s) Explanation of the methods of assigning clinical care and the standards of clinical practice							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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t) Handover communication u) Training in basic/advanced life support techniques v) Technology and equipment use including artificial intelligence, digital care and robotics							

STANDARD 11.2.3 (NEW)

The operating suite services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the operating suite staff, ensuring a safe and healthy work environment.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 11.2.3.1 (CORE)							
The Operating Suite Services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being. a) A health-promoting environment, e.g., stress management, burn out, staff engagement opportunities, workload monitoring, management of work life	1. The promotion of staff well-being may involve the following:						
	a. Evidence of a health promoting environment e.g., workplace wellness programme;						
	b. Evidence of proper supervision of staff; and						

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RITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
balance, healthy, lifestyle programmes e.g. Workplace Wellness Programs, Community-Based Health Initiatives; b) Staff shall be provided with appropriate supervision, support, and advice e.g., mentor mentee program; and c) There shall be clear procedures for the effective management of underperformance e.g., feedback on performance review or performance appraisal report.	c. Evidence of staff appraisal programme with feedback on underperformance.						
CRITERION 11.2.3.2 (CORE)							
The Operating Suite Services shall establish a safe mechanism for operating suite staff to express grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety.	1. Operating suite staff suggestions and grievance reporting and processing mechanisms are available;						
	2. The resolution of workplace issues may involve the following:						
	a. Measures and evidence of operating suite staff protection including whistleblowers against violence, bullying, and harassment e.g., awareness campaigns, anonymous reporting channel, Whistleblower policy; and						

RITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	b. Documented policies and procedures for violence activation and operating suite staff protection.						
CRITERION 11.2.3.3 (NEW)							
A system shall be created to gather staff feedback about their workplace experience such as burnout which shall be analysed and used to make improvements that enhance the work environment, staff satisfaction, and organisation culture.	1. Staff feedback (e.g., minutes of sessions or staff satisfactions survey):						
	a. Evidence of action or improvement taken.						
CRITERION 11.2.3.4 (NEW)							
The operating suite services shall track sick leave and operating suite turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning	1. Evidence that workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments. The results shall be used to create focused actions that improve operating suite staff well-being, solve problems, and help retain operating suite employees.						

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TOPIC 11.3
POLICIES AND PROCEDURES

STANDARD 11.3.1
DEVELOPMENT, DERIVATION AND DOCUMENTATION
Documented policies and procedures shall reflect current knowledge and practice for the Operating Suite Services and are consistent with the goals and objectives of the Operating Suite Services and relevant regulations and statutory requirements.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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, current standard practices and Patients and Family Rights. 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.	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; and						
	4. The policies and procedures are endorsed and dated.						
CRITERION 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.	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;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.	3. Documented cross departmental policies; and						
	4. Evidence that policies and procedures are consistent with current international standards of perioperative care.						
CRITERION 11.3.1.3							
Current policies and procedures are communicated to all staff.	1. Training and briefing on the current policies and procedures/Minutes of meetings; and						
	2. Circulation list and acknowledgement.						
CRITERION 11.3.1.4 (CORE)							
There is evidence of compliance with policies and procedures.	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; and						
	d. practices not in line with established policies and procedures noted from incident reports.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 11.3.1.5							
Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.						
CRITERION 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; and x) Prevention of radiation hazards;	1. Policies and procedures include all but not limited to the elements listed in (a) to (m);						
	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; and						
	4. An SOP for difficult intubation management shall be available, outlining decision-making based on patient condition, trained personnel availability, and equipment readiness.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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 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							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and m) Prevention of laser hazard.							
CRITERION 11.3.1.7 (CORE)							
Policies and procedures are integrated in the care of patients incorporating but not limited to the following: a) Admission process; b) Preoperative assessment; c) Intraoperative protocols; d) Post-anaesthesia care; e) Transition of care process; f) Surgical site infection prevention; g) Day of surgery admission protocols; h) Environment of care for surgical patients; and i) Discharge process. There is evidence of compliance with policies and procedures on various types of patients.	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.						

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TOPIC 11.4
FACILITIES AND EQUIPMENT

STANDARD 11.4.1
There are adequate physical facilities and equipment for the safe and efficient functioning of the Operating Suite Services.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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;	1. The design and layout of the Operating Suite Services provide adequate space and includes features as listed in (a) to (i); and						
	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.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
h) Staff facilities like tea room, locker area, on-call room; and i) There is plan for providing improved staff facilities when the Facility undergoes refurbishment or redevelopment if any of the above are deemed inadequate.							
CRITERION 11.4.1.2							
The design of the Operating Suite Services supports efficient systems for the management of perioperative services which include: a) Operating rooms are treated as "clean" and “ultra clean” rooms whenever clinically required with yearly performance test; b) Fire detection, alarm, and suppression systems; firefighting equipment and appropriate sign posting; c) Ventilation system should provide positive pressure	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 comply to relevant standards;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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;	3. Fire escape plan clearly posted; 4. Verification of the appropriateness of the design of the operating suite by onsite inspection; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and l) Colour coding for electrical outlets shall be according to international standards.	5. Logbook on medical gas monitoring.						
CRITERION 11.4.1.3							
The requirements for other systems to support perioperative services include:	1. Verification of other support systems in the operating suite includes items listed (a) to (e);						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.	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); and						
	3. Temperature maintained at 18°C - 22°C and relative humidity 50% - 60%.						
CRITERION 11.4.1.4							
The Operating Suite Services shall comply with all safety features in accordance with	1. The operating theatre complies with all safety features in accordance to regulatory requirements as addressed in (a) to (e);						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
regulatory requirements which include: a) Compliance with electrical standards for cardiac-protected or body-protected electrical areas, where required. In critical life support applications where leakage current from equipment can be detected by isolation transformers Line Isolation and Overload Monitor (LIOM); 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 hich comply with Malaysian Standards; and 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	2. Verification of the above through on-site inspection;						
	3. Warning signs if radiology equipment is in use; and						
	4. If operating theatre is not lead-lined, there must be adequate protective shields available.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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; 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 Anesthesiologists or the College of Anaesthesiologists of the Academy of Medicine of Malaysia (current edition); d) Emergency and resuscitation equipment and supplies including those required for difficult intubation shall be available and maintained, supported by clear operating instruction	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).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
and evidence that staff are trained in their use 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.							
CRITERION 11.4.1.6							
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); and						
	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.						
CRITERION 11.4.1.7							
Emergency biomedical equipment is thoroughly tested as a routine, e.g. defibrillators are discharged and output checked	1. Records on regular inspection and checking biomedical equipment (electrocardiogram strips for defibrillator; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
as per recommended or after each use, and the results recorded.	2. Policy and schedule on checking biomedical equipment.						
CRITERION 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.	1. Planned Preventive Maintenance records such as schedule, stickers, etc;						
	2. Planned Replacement Programme where applicable;						
	3. Complaint records; and						
	4. Asset inventory.						
CRITERION 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.	1. User training records;						
	2. Competency assessment record;						
	3. Letter of authorisation; and						
	4. List of staff trained and authorised to operate specialised equipment.						
CRITERION 11.4.1.10 (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care.						

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TOPIC 11.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 11.5.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 11.5.1.1							
There are periodical 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; and g) Innovation	1. Planned performance improvement activities include (a) to (g);						
	2. Records on performance improvement activities;						
	3. Minutes of performance improvement meetings;						
	4. Performance improvement studies;						
	5. Mortality and morbidity audits with remedial actions; and						
	6. Records on innovation if available.						
CRITERION 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.	1. Minutes of Meetings;						
	2. Letter of assignment of responsibilities; and						
	3. Job description.						

DISTRIBUTION

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 11.5.1.3 (CORE)							
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.	1. System for incident reporting is in place, which include:						
	a. Training of staff;						
	b. Policy on incident reporting;						
	c. Methodology of incident reporting; and						
	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; and						
	8. Feedback given to staff regarding incident reporting.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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) Mandatory indicator compliance to Safe Surgery Saves Lives (SSSL) practice; Elective operation cancellation rate (Target: <10%); b) Percentage of patients awaiting emergency surgery for more than 24 hours due to lack of theatre time (Target: <1%); c) Number of patients returning to surgery within 24 hours (sentinel event); d) Time taken for lower segment caesarean section (LSCS) for fetal distress within 30 minutes of informing operating theatre (sentinel event); e) Number of unnecessary delay in starting surgery after induction of anaesthesia due to lack or personnel or equipment (sentinel event); f) Number of incidents reported in the operating room; g) Number of peri-operative mortality and morbidity review; h) Percentage of cases done as day care or day of surgery admission (DOSA) (30% of all surgeries); and	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.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
i) Number of adverse events following positioning (sentinel event)							
CRITERION 11.5.1.5 (NEW)							
The Services participates in the Facility's safety culture assessment. The results are utilized by Service leadership to inform and guide efforts to improve the culture of safety within the Service.	1. Safety Culture Survey for staff.						
CRITERION 11.5.1.6							
Feedback on the results of safety and performance improvement activities are regularly communicated to the staff to promote transparency, shared learning, and active engagement in improvement initiatives.	1. Results on safety and performance improvement activities are accessible to staff through education sessions, meetings and digital communications.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 11.5.1.7							
Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.	1. Documentation on performance improvement activities and performance indicators; and						
	2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						

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SERVICE SUMMARY	
OVERALL RATING :	-
OVERALL RISK :	-

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SERVICE STANDARD 12: AMBULATORY CARE SERVICES

PREAMBLE

Ambulatory care is defined as scheduled procedures provided to patients who do not require an overnight hospital stay. It is a process of care in which suitable patients are admitted, treated, and discharged on the same day. Ambulatory care is performed for diagnostic and therapeutic procedures that may require topical, local, regional, monitored anaesthetic care, or general anaesthesia, and that carry minimal or no risk of post-operative complications but require a period of observation in the Ambulatory Care Centre. Ambulatory care services can be provided in hospital-based.

There are guidelines to specifying which patients can be treated, which procedures can be performed, and under what forms of anaesthesia/sedation ambulatory care may be provided.

An ambulatory care centre may perform procedures that require a patient to stay for no more than 23 hours. Patients are either discharged in an ambulatory condition, without the need for constant or continuous care or supervision and without risk to their ongoing well-being or are transferred to a hospital. [Reference: Private Healthcare Facilities and Services Act 1998 (Act 586)]

TOPIC 12.1
ORGANISATION AND MANAGEMENT

STANDARD 12.1.1
The Ambulatory Care Services are organized to provide safe and efficient care for ambulatory patients. The service includes patients treated and managed in the day care for conditions, diagnostic and interventional procedures.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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 are measurable in line with the						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.		Facility/Centre's statements are available, endorsed and dated;					
	3.	Evidence of planned reviews of the above statements (at least once in 3 years or in the event of any major changes);					
	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.					
CRITERION 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; b) Is accessible to all staff and clients;	1.	Clearly delineated current organization 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.	Organization chart of the service is endorsed, dated and accessible; and					

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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	3. The organization chart is revised when there is a major change in any of the items (d)(i) to (iv).						
CRITERION 12.1.1.3							
The Governing Body shall ensure that Ambulatory Care Services are organized 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; and 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.	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; and						
	5. Minutes of meetings						
CRITERION 12.1.1.4							

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
The Ambulatory Care Services shall adopt a governing framework in accordance with statutory and other legal requirements..	1. License to operate (Private Healthcare Facility)/Gazettement letters and supporting documents (Public Healthcare Facility); and						
	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.						
CRITERION 12.1.1.5 (CORE)							
The Person In Charge (PIC) of the Ambulatory Care Services has : a) Representation of the Service in relevant committees; b) Heads clinical staff meetings; and c) Provides regular input on the operations of the Services to the Management Team.	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; and						
	4. Letter of appointment for representation in relevant committees, e.g., Operating Theatre Committee and minutes of meetings.						
CRITERION 12.1.1.6							
Regular staff meetings are held between the Head of Service/Centre and staff with	1. Minutes are accessible, disseminated and acknowledged by the staff;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.	2. Attendance list of members with adequate representation of the service;						
	3. Frequency of meetings as scheduled; and						
	4. Discussion and resolutions are implemented.						
CRITERION 12.1.1.7							
The Head of the Ambulatory Care Services/Centre is involved in the planning, justification and management of the budget and resource utilization of the services	1. Minutes of Facility-wide management meeting;						
	2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service; and						
	3. Approved budget and resources.						
CRITERION 12.1.1.8							
The Head of the Ambulatory Care Services/Centre is involved in the appointment and/or assignment of staff	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; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	5. Duty roster.						
CRITERION 12.1.1.9							
Ambulatory Care Services are provided appropriate to the Facility's scope of medical and surgical services.	1. List of ambulatory care services provided; and						
	2. Patient registration records.						
CRITERION 12.1.1.10							
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.	1. Records are available but not limited to the following;						
	2. Workload / census:						
	a. Annual report;						
	b. Accident/incident reports;						
	c. Staffing number and staff profile;						
	d. Staff training records;						
	e. Data on performance improvement activities, including performance indicators.						
CRITERION 12.1.1.11							
Appropriate records are maintained by the Ambulatory Care Services/Centre which are adequate for clinical, medicolegal, and evaluation	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; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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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. 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.	3. Record of the procedure/operation performed and documented in the patient's medical record details the following:						
		a. Procedure/ Operation performed;					
		b. Date and time;					
		c. Type of anesthesia;					
		d. Personnel involved in the procedure/operation;					
		e. Findings;					
		f. Record of accountable items used;					
		g. The dressings applied and drainage systems inserted (where applicable);					
		h. Postprocedural/postoperative orders; and					
		i. Discharge and follow up notes.					
CRITERION 12.1.1.12 (NEW)							
The Head of Services shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and	1. Documented and approved BCP for unanticipated situations;						
	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes; a. Likelihood; b. Impact; c. Assigned ownership, and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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alternative arrangements to continue care.	d. Risk treatment.						
	3. Clear actions and staff responsibilities during disruption.						
	4. Record of drills or tests, with follow-up actions, if conducted.						
	5. Review of Risk Register.						

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STANDARD 12.1.2

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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 12.1.2.1							
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;	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, recognized certification, etc);						
	c. Procedures for managing shortfall in service; and						
	d. Involvement in performance measurement of the relevant services provided to the Facility.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.							

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TOPIC 12.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD 12.2.1
The Ambulatory Care Services shall be directed by a qualified and competent National Specialist Register (NSR) registered 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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 12.2.1.1							
The Head and staff of the 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 Ambulatory Care Services/Centre shall conform to the statutory requirements.	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; and						
	3. Training and competency records						
CRITERION 12.2.1.2							
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	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;						

DISTRIBUTION

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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 (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.	5. Availability of the list of specialised procedures requiring credentialing and privileging; and 6. Availability of list of specialised procedures to include procedures specific to the disciplines performed by medical practitioners; competency records/logbooks.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 12.2.1.3							
The authority, responsibilities and accountabilities of the Head Ambulatory Care Services/Centre are clearly delineated and documented.	1. Appointment/assignment letter for Head of Service; and						
	2. Description of duties and responsibilities.						
CRITERION 12.2.1.4							
Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the need of the services a) In highly specialized services, there should be at least one staff that is post basic trained; b) There shall be minimum one (1) nurse to four (4) patients at all times in pre-procedure / pre- operativemand recovery bay; and c) There shall be minimum two (2) registered nurses / MA (PPP)/in one (1) operating room, including at least one (1) post basic trained nurse in each operating room.The number of nurses/ MA(PPP) shall be commensurate with the number of functional procedure and operating rooms	1. Number of staff and qualification should commensurate with workload;						
	2. Staffing pattern;						
	3. Duty roster; and						
	4. Census and statistics.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 12.2.1.5							
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 reporting; 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; and 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; and						
	4. The job description is acknowledged by the staff and signed by the Head of Service and dated.						
CRITERION 12.2.1.6 (CORE)							
Clinical staff performs within the privileges conferred.	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; and						
	b. Clinical notes						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 12.2.1.7							
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.	2. 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.						
CRITERION 12.2.1.8 (NEW)							
There is a structured orientation programme for all newly appointed, contracted and outsourced staff to the Surgical Related Services including medical practitioners and for those new to specific areas that include but not limited to the following: <u>General</u> a) Vision and mission of the Facility b) Organization chart and reporting structure of the Facility	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 (g); and						
	3. Attendance list						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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c) Environment and facility safety policies and procedures including sustainability practices d) Infection control policies and procedures e) Policies for performance management, patient safety (IPSG/MPSG) and risk management f) Ethical practices and code of conduct including medicolegal awareness g) Management of aggression, violence and harassment h) Patient and family rights <u>Services</u> i) Goals, objectives and organizational structure of Surgical Services j) Policies and procedures relevant to Surgical Services k) Working instructions for patient care l) Service continuity plan for Surgical Services in response to internal and external disasters <u>Job-specific</u> m) Explanation of particular duties and functions n) Explanation of the methods of assigning clinical care and the standards of clinical practice o) Handover communication p) Training in basic/advanced life support techniques							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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q) Technology and equipment use including artificial intelligence, digital care							
CRITERION 12.2.1.9							
There are continuing education activities for staff including medical practitioners to pursue professional interests and to prepare for current and future changes in practice.	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; and						
	4. Certificate of attendance/degree/post basic training.						
CRITERION 12.2.1.10							
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.	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; and						
	4. Training module						
CRITERION 12.2.1.11							
Medical practitioners (including consultants, specialists and	1. Performance appraisal for medical practitioners (including consultants,						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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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.	specialists and medical officer) and staff is completed upon probationary period and as an annual exercise.						

STANDARD 12.2.2 (NEW)

The Ambulatory Care services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the nursing staff, ensuring a safe and healthy work environment.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 12.2.2.1 (CORE) (NEW)							
The ambulatory care services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being. a) A health-promoting environment, e.g., stress management, burnout, staff engagement opportunities, workload monitoring, management of work life balance, healthy, lifestyle programmes e.g. Workplace Wellness Programs, Community-Based Health Initiatives; b) Staff shall be provided with appropriate supervision, support, and advice e.g., mentor mentee program; and	1. The promotion of staff well-being may involve the following:						
	a. Evidence of a health promoting environment e.g., workplace wellness programme;						
	b. Evidence of proper supervision of staff;						
	c. Evidence of staff appraisal programme with feedback on underperformance.						

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
c) There shall be clear procedures for the effective management of underperformance e.g., feedback on performance review or performance appraisal report.							
CRITERION 12.2.2.2 (CORE) (NEW)							
The ambulatory care services shall establish a safe mechanism for ambulatory care staff to express grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety.	1. Ambulatory care staff suggestions and grievance reporting and processing mechanisms are available; and						
	2. The resolution of workplace issues may involve the following:						
	a. Measures and evidence of ambulatory care staff protection including whistleblowers against violence, bullying, and harassment e.g., awareness campaigns, anonymous reporting channel, Whistleblower policy; and						
	b. Documented policies and procedures for violence activation and ambulatory care staff protection.						
CRITERION 12.2.2.3 (NEW)							
A system shall be created to gather ambulatory care staff feedback about their workplace	1. Ambulatory care staff feedback (e.g., minutes of sessions or nursing staff satisfactions survey):						

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experience such as burnout which shall be analysed and used to make improvements that enhance the work environment, ambulatory care staff satisfaction, and organization culture.	a. Evidence of action or improvement taken.						
CRITERION 12.2.2.4 (NEW)							
The ambulatory care services shall track sick leave and staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning	1. Evidence that workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments. The results shall be used to create focused actions that improve staff well-being, solve problems, and help retain employees.						

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TOPIC 12.3
POLICIES AND PROCEDURES

STANDARD 12.3.1
DEVELOPMENT, DERIVATION AND DOCUMENTATION
Documented policies and procedures shall reflect the complexity of the services and commensurate with the current knowledge and evidence based practice for the ambulatory care services, and they are consistent with statutory requirements and the goals and objectives of the Ambulatory Care Services/Centre.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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, current standard practices, clinical practice guidelines and Patients and Family Rights. 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.	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; and						
	4. The policies and procedures are endorsed and dated.						
CRITERION 12.3.1.2 (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	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; and						

DISTRIBUTION

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with reference to relevant sources involved.	3. Documented cross departmental/centre policies.						
CRITERION 12.3.1.3							
Current policies and procedures are communicated to all staff.	1. Training and briefing on the current policies and procedures/Minutes of meetings; and						
	2. Circulation list and acknowledgement.						
CRITERION 12.3.1.4 (CORE)							
Policies and procedures are integrated in the ambulatory care patients incorporating but not limited to following pathways: a) Admission process; b) Preoperative/ pre-procedure assessment; c) Intraoperative/ intra-procedure protocols; d) Post-anesthesia/sedation care; e) Transition of care process; f) Prevention and control of infection; g) Day of surgery/ procedure admission protocols; h) Environment of care for ambulatory care patients; and i) Discharge process. There is evidence on compliance with policies and procedures on various types of patients.	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.					

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CRITERION 12.3.1.5							
Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.	1. Copies of relevant policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.						
CRITERION 12.3.1.6 (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) 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	1. Documented policies that address (a) to (l).						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
credentialed/privileged 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) Pain management; j) A dedicated anesthetist is present or readily available until all patients who have undergone general anesthesia/deep sedation are discharged; k) The discharge procedure ensures the patient is given relevant documented postoperative instructions; and l) There is a responsible person/family member accompanying the discharged patient undergone the procedures under general anesthesia. The address and phone number of the discharge person/family members are recorded in the medical record.							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 12.3.1.7							
A registered medical practitioner (RMP) shall be trained to carry out procedural sedation. When performed by non-anesthesiologists, the level of sedation should be kept at minimal to moderate. Deep sedation should ONLY be done in the presence of an anesthesiologist throughout the procedure.	1. Credentialed and privileged of registered medical practitioner to carry out procedural sedation;						
	2. Policy on management of deep sedation; and						
	3. Anaesthesiologist is present throughout the deep sedation procedure as observed during survey on site.						
CRITERION 12.3.1.8							
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 Ambulatory Care Services;. c) Type of anesthesia and post anesthetic effects; d) Provision for after-hours contact and emergency care; e) The patient's post-discharge responsibilities/instructions; and f) Follow-up instruction.	1. Patient information pamphlet;						
	2. Relevant contact number for any emergency care; and						
	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; and						
	c. Written follow up instruction.						
CRITERION 12.3.1.9							
Emergency management and patient transfer policy for	1. Policies and procedures on management of emergency patients include:						
	a. Patient transfer; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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periprocedural/perioperation complications	b. Referral details including notes on patient's medical history.						
	2. Verification on compliance as per patient notes on transfer arrangement; and						
	3. Policy on Code Blue.						
CRITERION 12.3.1.10							
The 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.	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; and						
	3. Contents in the referral letter are appropriately written and includes acceptance of the patient by the referred facility, name of receiving person.						
CRITERION 12.3.1.11							
There are policies and procedures for the Theatre Sterilising Supply Unit (TSSU).	1. Policies and procedures that address TSSU processes but not						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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The policies and procedures shall include the following: a) Receiving and decontamination processes (disassembling, washing, cleaning and disinfection); b) Packaging process (inspection, functionality check and packing); c) Sterilization 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 utilization (turnover time); j) Safety practices in TSSU; and k) Utilisation of "flash" autoclave in operating theatre and clinics.	limited to items (a) to (k) are available.						
CRITERION 12.3.1.12							
Where single use devices or instruments are to be reused, the processes for reprocessing are consistent with relevant national guidelines and international standards.	1. Policy on single-use medical surgical instruments, equipment or supplies; and						
	2. Compliance with policy.						

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CRITERION 12.3.1.13							
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	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; and						
	3. Sterilizer records, e.g. number of cycles.						
CRITERION 12.3.1.14 (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) Lectronic prescribing, using an open or closed network if practiced, conform to established conventions with regards to the identity of the prescriber and patient; and c) Drugs dispensed and administered are based on	1. Policies and procedures include (a) to (c) are available;						
	2. Security access is established for electronic prescribing;						
	3. Records on original prescription; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
the original of the medical practitioner's order. Drug orders are not transcribed.	4. Updated sample of doctors' signature for manual prescribing.						

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TOPIC 12.4
FACILITIES AND EQUIPMENT

STANDARD 12.4.1
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 clinics (including facility providing diagnostic services), day care wards, operating theatre (with Anaesthetic Services and without Anaesthetic Services) and Central Sterilising Supply Services.

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CRITERION 12.4.1.1							
There are adequate and appropriate facilities and equipment with proper utilization of space to enable staff to carry out their professional, teaching and administrative functions.	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).						

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CRITERION 12.4.1.2							
Existing facilities shall take cognisance of the safety of staff and patients.	1. Design and layout of the 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 Ambulatory Care Services, e.g. emergency trolley, functioning patient call bell, etc; and						
	4. Equipment should have scheduled planned preventive maintenance (PPM).						
CRITERION 12.4.1.3							
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	1. Appropriate telecommunication modalities available for daily operation and during emergencies.						
CRITERION 12.4.1.4							
There is documented evidence that equipment and instruments complies with relevant national/international standards	1. Testing, commissioning and calibration records (certificates or stickers);						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
and current statutory requirements. All biomedical equipment shall comply with Medical Device Act 2012.	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; and						
	3. Medical device registration certificate from Medical Device Authority.						
CRITERION 12.4.1.5 (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.	1. Planned Preventive Maintenance records such as schedule, stickers, etc;						
	2. Planned Replacement Programme where applicable;						
	3. Complaint records; and						
	4. Asset inventory.						
CRITERION 12.4.1.6							
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.	1. Records on regular inspection and checking biomedical equipment (electrocardiogram strips for defibrillator); and						
	2. Policy and schedule on checking biomedical equipment.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 12.4.1.7							
Where specialized equipment is used, only staff who are trained and privileged by the Facility operate such equipment.	1. User training records;						
	2. Competency assessment record;						
	3. Letter of privileging;						
	4. List of staff trained and competent to operate specialised equipment.						
CRITERION 12.4.1.8							
Equipment is upgraded (based on evidence) from time to time to keep pace with advancement in operative and diagnostic techniques and technology.	1. Equipment are being replaced and upgraded to meet current standard of care and advancement in technology in a planned and systematic manner.						
CRITERION 12.4.1.9 (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care.						

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STANDARD 12.4.2

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 12.4.2.1							
Anaesthetic delivery systems shall have safety features to prevent accidental hypoxia or disconnection of breathing circuits during mechanical ventilation. These will include antihypoxic devices, alarms for oxygen pressure failure, and ventilator disconnect alarms.	1. Availability of general anaesthesia (GA) machines with the required safety features.						
CRITERION 12.4.2.2							
Anaesthetic waste gases and vapours shall be scavenged.	1. Evidence of functional Anaesthetic Gas Scavenging Systems.						
CRITERION 12.4.2.3							
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.	1. Availability of emergency alert.						

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STANDARD 12.4.3

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 12.4.3.1							
The patient shall be in clean linen throughout the procedure.	1. Policy on linen supply; and						
	2. Patients have clean linen as evidenced on-site.						
CRITERION 12.4.3.2							
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.	1. Policy on management of soiled linen;						
	2. Soiled linen is collected in dedicated colour coded linen bag as observed on inspection; and						
	3. Adequate supply of alginate bag for contaminated linen.						
CRITERION 12.4.3.3							
Soiled linen from infectious patients is clearly identified; staff shall take appropriate precautions in handling and processing this type of linen.	1. Policy on handling contaminated linen;						
	2. Use of colour coded linen bag for different types of linen; and						
	3. Use of alginate bag for contaminated linen as evidenced on site.						
CRITERION 12.4.3.4							
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	1. Policies and Procedures on Linen Services that address but not limited to items (a) to (b) are available.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
transporting prior to washing; and b) Physical appearance and condition of linen.							
CRITERION 12.4.3.5 (CORE)							
Clean linen is transported and stored separately from soiled linen.	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; and						
	4. Dedicated clean linen storage area.						

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TOPIC 12.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 12.5.1
The Head of 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 Ambulatory Care Services shall ensure compliance to monitoring of specific performance indicators.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 12.5.1.1							
The Head of the 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.	1. Plans for patient safety, quality improvement and risk management.						
CRITERION 12.5.1.2							
There are periodical 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 g) Innovation	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; and						
	6. Records on innovation if available.						
CRITERION 12.5.1.3							
The Head of Ambulatory Care Services/Centre has assigned the	1. Minutes of Meetings;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
responsibilities for planning, monitoring and managing safety and performance improvement activities to appropriate individual/personnel within the respective services.	2. Letter of assignment of responsibilities; and						
	3. Job description.						
CRITERION 12.5.1.4							
The Head of the 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.	1. System for incident reporting is in place, which include:						
	a. Training of staff;						
	b. Policy on incident reporting;						
	c. Methodology of incident reporting; and						
	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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	7. Acknowledgment by Head of Service and PIC/Hospital Director; and						
	8. Feedback given to staff regarding incident reporting.						
CRITERION 12.5.1.5 (CORE)							
The Ambulatory Care Services/Centre shall address Patient Safety Goals to prevent potential errors from occurring. a) **World Health Organization (WHO) Global Patient Safety Challenges** i) Identify patient correctly ii) Improve effective communication iii) Improve the safety of high-alert medications iv) Ensure correct-site, correct-procedure, correct-patient surgery v) Reduce the risk of healthcare associated infections vi) Reduce the risk of patient harm resulting from fall b) **World Health Organization (WHO) Patient Safety Solutions** i) Look-Alike, Sound-Alike Medication Names ii) Patient Identification iii) Communication During Patient Hand-Overs iv) Performance of Correct Procedure at Correct Body Site	1. Report on implementation of WHO Global Patient Safety Challenges & Patient Safety Solutions and Malaysian Patient Safety Goals.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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v) Single Use of Injection Devices vi) Improved Hand Hygiene to Prevent Healthcare Associated Infections c) **Malaysian Patient Safety Goals** i) To implement Clinical Governance ii) To implement the WHO's 1st Global Patient Safety Challenge: "Clean Care is Safer Care" iii) To implement the WHO's 2nd Global Patient Safety Challenge: "Safe Surgery Saves Lives" iv) To improve the accuracy of patient identification v) To ensure medication safety vi) To improve clinical communication by implementing critical value programme vii) To reduce patient fall viii) To implement an Incident Reporting and Learning System							
CRITERION 12.5.1.6 (CORE)							
There is tracking and trending of performance indicator specific to ambulatory care service provided (Refer to performance indicator manual)	1. Specific performance indicators monitored;						
	2. Records on tracking and trending analysis; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	3. Remedial measures taken where appropriate.						
CRITERION 12.5.1.7 (NEW)							
The Services participates in the Facility's safety culture assessment. The results are utilized by Service leadership to inform and guide efforts to improve the culture of safety within the Service.	1. Safety Culture Survey for staff.						
CRITERION 12.5.1.8							
Feedback on results of safety and performance improvement activities are regularly communicated to the staff to promote transparency, shared learning, and active engagement in improvement initiatives.	1. Results on safety and performance improvement activities are accessible to staff through education sessions, meetings and digital communications.						
CRITERION 12.5.1.9							
Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved	1. Documentation on performance improvement activities and performance indicators; and						
	2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						

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TOPIC 12.6
SPECIAL REQUIREMENTS

STANDARD 12.6.1
ENDOSCCOPY SERVICES

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 12.6.1.1							
Appropriate records are maintained by the Ambulatory Endoscopy Services which are adequate for clinical, medicolegal, and evaluation purposes and include the following:	1. Record of the scopes used for the procedures;						
	2. Record of reprocessing of scopes;						
	3. Anaesthetic practice areas are aligned with safety and security measures concerning artificial intelligence;						
	4. Reprocessing of scopes conform to Association for the Advancement of Medical Instrumentation (AAMI) ST91 practices, preferably with an AER; and						
	5. There is Infection Control surveillance on reprocessing and storage of scopes.						

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SERVICE SUMMARY	
OVERALL RATING :	-
OVERALL RISK :	-

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SERVICE STANDARD 12A : AMBULATORY CARE SERVICES - ENDOSCOPY SERVICES

PREAMBLE

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:

1. ***The patient are scheduled / elective) to undergo treatment***
2. ***The scheduled Procedures have been done***
3. ***Procedures carried out required a short recovery period together with the complete documentation in the progress of the patient during the observation period.***
4. ***Patients discharge from observation ward in the same calendar day.***

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.

TOPIC 12A.1
ORGANISATION AND MANAGEMENT

STANDARD 12A.1.1

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.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of critical nursing services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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CRITERION 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,	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 are measurable in line with the						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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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.	Facility statements available, endorsed and dated;						
	3. Evidence of planned reviews of the above statements (at least once in 3 years or in the event of any major changes);						
	4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc); and						
	5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.						
CRITERION 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; b) Is accessible to all staff and clients;	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; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
c) Includes off-site services if applicable; and d) Is revised when there is a major change in any of the following: i) Organisation; ii) Functions; iii) Reporting relationships; and iv) Staffing patterns	3. The organization chart is revised when there is a major change in any of the items (d)(i) to (iv).						
CRITERION 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 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; and d) Ensure that the medical practitioners are involved in the formulation of policies and procedures concerning patient care appropriate to	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 and Dental Advisory Committee/Medical Advisory Committee and ward meetings;						
	5. Minutes of Meetings; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
the scope of services of the Facility.	6. Proper and adequate equipment according to current standards.						
CRITERION 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 b) Representation of the Service in clinical staff liaison meetings; and c) Involvement and provide regular input to the Senior Management Team.	1. Letter of appointment and delineation of duties and responsibilities of the Head of the Endoscopy Service; and						
	2. Letter of appointment for representation in relevant committees, e.g. Ambulatory Care services.						
CRITERION 12A.1.1.5 (CORE)							
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	1. Minutes are accessible, disseminated and acknowledged by the staff;						
	2. Attendance list of members with adequate representation of the service;						
	3. Frequency of meetings as scheduled; and						
	4. Discussion and resolutions are implemented.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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CRITERION 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.	1. Minutes of Facility-wide management meeting;						
	2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service; and						
	3. Approved budget and resources.						
CRITERION 12A.1.1.7							
The Head of the Ambulatory Endoscopy Services is involved in the appointment and /OR assignment of staff	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; and						
	5. Duty roster.						
CRITERION 12A.1.1.8							
Ambulatory Endoscopy Services are provided appropriate to the Facility's scope of medical and surgical services.	1. List of ambulatory Endoscopy services provided; and						
	2. Patient registration records.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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CRITERION 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.	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; and						
	f. Data on performance improvement activities, including performance indicators.						
CRITERION 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;	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;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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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; and 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.	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. Suite the dressings applied and drainage systems inserted (where applicable);						
	h. Postoperative orders;						
	i. Discharge and follow up notes;						
	j. Record of the scopes used for the procedures; and						
	k. Record of reprocessing of scopes.						
CRITERION 12A.1.1.11 (CORE)							
Clinical staff performs within the privileges conferred	1. Verification of procedures performed by individual at point of care within the awarded privileging rights with evidence of:						
	a. List of procedures privileged; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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	b. Clinical notes.						
CRITERION 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.	1. Availability of relevant clinical support services;						
	2. Floor plan indicates accessibility to supporting services; and						
	3. Appropriate telecommunication modalities and system.						
CRITERION 12A.1.1.13 (NEW)							
The Head of Services shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	4. Documented and approved BCP for unanticipated situations;						
	5. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment.						
	6. Clear actions and staff responsibilities during disruption;						
	7. Record of drills or tests, with follow-up actions, if conducted; and						
	8. Review of Risk Register.						

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TOPIC 12A.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD 12A.2.1
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.

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CRITERION 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.	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 certification/registration;						
	2. Appointment/assignment letter; and						
	3. Training and competency records.						
CRITERION 12A.2.1.2							
The authority, responsibilities and accountabilities of the Head of Ambulatory Endoscopy Services are clearly delineated and documented.	1. Appointment/assignment letter for Head of Endoscopy Service; and						
	2. Description of duties and responsibilities.						
CRITERION 12A.2.1.3							
Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the need of the services.	1. Number of staff and qualification should commensurate with workload;						
	2. Staffing pattern;						

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	3. Duty roster; and						
	4. Census and statistics.						
CRITERION 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; and 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; and						
	4. The job description is acknowledged by the staff and signed by the Head of Endoscopy Service and dated.						
CRITERION 12A.2.1.5							
Personnel records on training, staff development, leave and	1. Staff personal records include:						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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others are maintained for every staff. **Note:** Staff personal record may be kept in Human Resource Department as per Facility policy.	a. Staff biodata;						
	b. Qualification and experience;						
	c. Evidence of current registration;						
	d. Training record;						
	e. Competency record and privileging;						
	f. Leave record; and						
	g. Confidentiality agreement.						
CRITERION 12A.2.1.6							
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.	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; and						
	4. Training module.						
CRITERION 12A.2.1.7							
There are continuing education activities for staff including medical practitioners to pursue	1. Training calendar includes in-house/external courses/ workshop/conferences;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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professional interests and to prepare for current and future changes in practice	2. Contents of training programme;						
	3. Training records on continuing education activities are kept and maintained for each staff including training in life support; and						
	4. Certificate of attendance/degree/post basic training.						
CRITERION 12A.2.1.8							
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.	1. Performance appraisal for staff including medical practitioners is completed upon probationary period and as an annual exercise; and						
	2. Certificate of attendance/degree/post basic training.						

STANDARD 12A.2.2
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.

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CRITERION 12A.2.2.1							
There is a structured orientation programme for all newly appointed, contracted and outsourced staff to the Services	1. Policy requiring all new staff to attend a structured orientation programme;						

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that include but not limited to the following: General a) Vision and mission of the Facility; b) Organisation chart and reporting structure of the Facility; c) Environment and facility safety policies and procedures including sustainability practices; d) Infection control policies and procedures; e) Policies for performance management, patient safety (IPSG/MPSG) and risk management; f) Ethical practices and code of conduct including medicolegal awareness; g) Management of aggression, violence and harassment; and h) Patient and family rights. Services i) Goals, objectives and organisational structure of Services; j) Policies and procedures relevant to Services; k) Working instructions for patient care; and l) Service continuity plan for Service in response to internal and external disasters. Job-specific	2. There is Services orientation programme with relevant topics not limited to topics covered from (a) to (q); and 3. Attendance list.						

m) Explanation of particular duties and functions; n) Explanation of the methods of assigning clinical care and the standards of clinical practice; o) Handover communication; p) Training in basic/advanced life support techniques; and q) Technology and equipment use including artificial intelligence, digital care and robotics.							

STANDARD 12A.2.3 (NEW)

The Ambulatory Care Services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the surgical related staff, ensuring a safe and healthy work environment.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 12A.2.3.1 (CORE)							
The Services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being. a) A health-promoting environment, e.g., stress management, burn out, staff engagement opportunities, workload monitoring, management of work life balance, healthy, lifestyle programmes e.g. Workplace Wellness Programs, Community-Based Health Initiatives; b) Staff shall be provided with appropriate supervision, support, and advice e.g.,	1. The promotion of staff well-being may involve the following:						
	a. Evidence of a health promoting environment e.g., workplace wellness programme;						
	b. Evidence of proper supervision of staff; and						
	c. Evidence of staff appraisal programme with feedback on underperformance.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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mentor mentee program; and c) There shall be clear procedures for the effective management of underperformance e.g., feedback on performance review or performance appraisal report.							
CRITERION 12A.2.3.2 (CORE)							
The Ambulatory Care Services shall establish a safe mechanism for Ambulatory Care Services staff to express grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety.	1. Ambulatory Care staff suggestions and grievance reporting and processing mechanisms are available;						
	2. The resolution of workplace issues may involve the following:						
	a. Measures and evidence of surgical staff protection including whistleblowers against violence, bullying, and harassment e.g., awareness campaigns, anonymous reporting channel, Whistleblower policy; and						
	b. Documented policies and procedures for violence activation and Ambulatory Care staff protection.						
CRITERION 12A.2.3.3 (NEW)							
A system shall be created to gather staff feedback about their	1. Staff feedback (e.g., minutes of sessions or staff satisfactions survey):						

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workplace experience such as burnout which shall be analysed and used to make improvements that enhance the work environment, staff satisfaction, and organisation culture.	a. Evidence of action or improvement taken.						
CRITERION 12A.2.3.4 (NEW)							
The Ambulatory Care services shall track sick leave and Ambulatory Care staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning.	1. Evidence that workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments. The results shall be used to create focused actions that improve Ambulatory Care staff well-being, solve problems, and help retain Ambulatory Care employees.						

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TOPIC 12A.3
POLICIES AND PROCEDURES

STANDARD 12A.3.1
DEVELOPMENT, DERIVATION AND DOCUMENTATION
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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, current standard practices and Patients and Family Rights. 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.	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; and						
	5. Policy should conform to the principle of sustainable care.						
CRITERION 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	1. Minutes of committee meetings on development and revision on policies and procedures;						
	2. Minutes of meeting with evidence of cross reference with the other departments/centre; and						

DISTRIBUTION

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
departmental collaboration is practised in developing relevant policies and procedures where applicable.	3. Documented cross departmental policies.						
CRITERION 12A.3.1.3							
Current policies and procedures are communicated to all staff.	1. Training and briefing on the current policies and procedures/Minutes of meetings; and						
	2. Circulation list and acknowledgement.						
CRITERION 12A.3.1.4							
Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.	1. Copies of relevant policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.						
CRITERION 12A.3.1.5 (CORE)							
Documented policies of a planned systematic approach to the provision of ambulatory Endoscopy care. These include: d) Available criteria for selection and assessment of cases; e) Policy on the use of sedation during procedures; f) Documented admission policies including age or disease limitations and the restrictions concerning the scope of clinical services offered;	1. Documented policies that address (a) to (k).						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
g) The booking and admission of patients comply with admission policies; h) 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 post-anaesthetic effects; iv) Provision for after-hours contact and emergency care; and v) Patient's post-discharge responsibilities/home care instructions. i) The requirements for a pre-anaesthetic assessment to be performed by a medical practitioner; j) Patient identification, with the nature of the procedures and site of the procedure verified by the surgeon and the consent documents checked; k) observations of the patient's pre-, intra-, and post-procedure status and vital signs are monitored and recorded in the medical record;							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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l) a dedicated anaesthetist is present or readily available until all patients who have undergone anaesthesia/sedation are discharged; m) 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; and n) Other relevant Patient and Family Rights policies.							
CRITERION 12A.3.1.6							
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;	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; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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d) Provision for after-hours contact and emergency care; and e) The patient's post-discharge responsibilities/instructions.	d. Written follow up instruction.						
CRITERION 12A.3.1.7							
The policies and procedures for management of emergency patients shall include arrangement for transfer of patients, where necessary.	1. Policies and procedures on management of emergency patients include:						
	a. Patient transfer; and						
	b. Referral details including notes on patient's medical history.						
	2. Verification on compliance as per patient notes on transfer arrangement.						
CRITERION 12A.3.1.8							
There is evidence on compliance with policies and procedures.	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; and						
	d. Practices in line with established policies and procedures.						

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TOPIC 12A.4
FACILITIES AND EQUIPMENT

STANDARD 12A.4.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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; and						
	g. Adequate facilities and equipment at each patient care area for safe care. (e.g. defibrillators, emergency cart, hand washing facilities etc)						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 12A.4.1.2							
Equipment, both for emergency and non-emergency usage, shall be appropriate to the level of care.	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; and						
	6. Scheduled checking of items in emergency trolley.						
CRITERION 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; a) Staff are aware of the appropriate procedures in the safe use and application of electromedical equipment;	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;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
b) Regular maintenance and monitoring of facilities and equipment, and a system to respond to breakdown repair and replacement; c) Emergency biomedical equipment, e.g. Defibrillator is checked at least once a day or after each use and the result is recorded; and d) Equipment complies with relevant standards, e.g. those set by Standards and Industrial Research Institute of Malaysia (SIRIM) and current statutory requirements.	4. Planned Preventive Maintenance (PPM), calibration and repair record; and						
	5. Defibrillator calibration testing record.						
CRITERION 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.	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; and						
	3. Planned Preventive Maintenance (PPM), calibration and repair records.						
CRITERION 12A.4.1.5							
There is documented evidence that equipment complies with relevant national/international	1. Testing, commissioning and calibration records (certificates or stickers); and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
standards and current statutory requirements.	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.						
CRITERION 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.	1. Planned Preventive Maintenance records such as schedule, stickers, etc;						
	2. Planned Replacement Programme where applicable;						
	3. Complaint records; and						
	4. Asset inventory.						
CRITERION 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.	1. User training records;						
	2. Competency assessment record;						
	3. Letter of authorisation; and						
	4. List of staff trained and competent to operate specialised equipment.						
CRITERION 12A.4.1.8							
Processing of the Endoscopy equipment a) Staff trained in processing of Endoscopy equipment; and b) Endoscopic cleaning / reprocessing room.	1. Trained, knowledgeable staff of ambulatory Endoscopy;						
		a. Training module; and					
		b. Logbook & certificate from Head of ambulatory Endoscopy services.					

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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	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).						
CRITERION 12A.4.1.9 (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care.						

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TOPIC 12A.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 12A.5.1
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.

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CRITERION 12A.5.1.1							
There are periodical 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 g) Innovation	1. Planned performance improvement activities include (a) to (g);						
	2. Records on performance improvement activities;						
	3. Minutes of performance improvement meetings;						
	4. Performance improvement studies;						
	5. Mortality and morbidity audits with remedial actions; and						
	6. Records on innovation if available.						
CRITERION 12.5.1.2							
The Head of Ambulatory Endoscopy Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement activities to appropriate	1. Minutes of meetings;						
	2. Letter of assignment of responsibilities; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
individual/personnel within the respective services.	3. Job description.						
CRITERION 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.	1. System for incident reporting is in place, which include:						
	a. Training of staff; and						
	b. Policy on incident reporting.						
	2. Methodology of incident reporting;						
	3. Register/records of incidents;						
	4. Completed incident reports;						
	5. Root Cause Analysis;						
	6. Corrective and preventive action plans;						
	7. Remedial measure;						
	8. Minutes of meetings;						
	9. Acknowledgment by Head of Service and PIC/Hospital Director; and						
	10. Feedback given to staff regarding incident reporting.						
CRITERION 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) cancellation rate of ambulatory Endoscopy cases;	1. Specific performance indicators monitored;						
	2. Records on tracking and trending analysis; and						
	3. Remedial measures taken where appropriate.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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b) No Show percentage of ambulatory Endoscopy cases; and c) Reprocessing of scopes should be done according to SOP (100% target)							
CRITERION 12A.5.1.5 (NEW)							
The Services participates in the Facility's safety culture assessment. The results are utilized by Service leadership to inform and guide efforts to improve the culture of safety within the Service.	1. Safety Culture Survey for staff.						
CRITERION 12A.5.1.6							
Feedback on results of safety and performance improvement activities are regularly communicated to the staff to promote transparency, shared learning, and active engagement in improvement initiatives.	1. Results on safety and performance improvement activities are accessible to staff through education sessions, meetings and digital communications.						
CRITERION 12A.5.1.7							
Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.	1. Documentation on performance improvement activities and performance indicators; and						
	2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						

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SERVICE SUMMARY	
OVERALL RATING :	-
OVERALL RISK :	-

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SERVICE STANDARD 12B : AMBULATORY CARE SERVICES - OPHTHALMOLOGY SERVICES

PREAMBLE

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.

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.

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)].

TOPIC 12B.1
ORGANISATION AND MANAGEMENT

Standard 12B.1.1
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.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 12B.1.1.1							
Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body;						

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Ophthalmology 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.	2. Goals and objectives of the Ophthalmology Ambulatory Care Services are measurable in line with the Facility statements available, endorsed and dated;						
	3. Evidence of planned reviews of the above statements (at least once in 3 years or in the event of any major changes);						
	4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc); and						
	5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.						
CRITERION 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; b) Is accessible to all staff and clients; c) Includes off-site services if applicable; and d) is revised when there is a major change in any of the following: i) Organisation;	1. Clearly delineated current organization 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. Organization chart of the service is endorsed, dated and accessible; and						
	3. The organization chart is revised when there is a major change in any of the items (d)(i) to (iv).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
ii) Functions; iii) Reporting relationships; and iv) Staffing patterns.							
CRITERION 12B.1.1.3							
The Governing Body shall ensure that Ophthalmology Ambulatory Care Services are organised in such a way as to: a) Facilitate the provision of Ophthalmology Ambulatory Care 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; and 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.	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 and Dental Advisory Committee/Medical Advisory Committee and service meetings; and						
	5. Minutes of meetings.						
CRITERION 12B.1.1.4							
The Ambulatory Care Services shall adopt a governing framework in accordance with statutory and other legal requirements.	1. License to operate (Private Healthcare Facility)/Gazettement letters and supporting documents (Public Healthcare Facility); and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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	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.						
CRITERION 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; and c) Provides regular input on the operations of the Services to the Management Team.	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 Dentistry Advisory Committee i.e. hospital-based service;						
	3. Minutes of meetings of Medical Dentistry Advisory Committee; and						
	4. Letter of appointment for representation in relevant committees, e.g., Operating Theatre Committee and minutes of meetings.						
CRITERION 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 meetings shall be	1. Minutes are accessible, disseminated and acknowledged by the staff;						
	2. Attendance list of members with adequate representation of the service;						
	3. Frequency of meetings as scheduled; minimum of two meetings per year; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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accessible, communicated to all staff of the service and implemented.	4. Discussion and resolutions are implemented.						
CRITERION 12B.1.1.7							
The Head of the Ambulatory Care Services/Centre is involved in the planning, preparation and management of the budget and resource utilisation of the services	1. Minutes of Facility-wide management meeting;						
	2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service; and						
	3. Documented evidence of approved budget and resources.						
CRITERION 12B.1.1.8							
The Head of the Ambulatory Care Services/Centre is involved in the appointment and/OR assignment of staff	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; and						
	5. Written and dated duty roster of staff.						
CRITERION 12B.1.1.9							
Ambulatory Care Services are provided appropriate to the Facility's scope of medical and surgical services.	1. List of ambulatory care services provided; and						
	2. Patient registration records.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Records are available but not limited to the following: a. Workload / census of procedure/ operation and day care ward; 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.					
CRITERION 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	1. Records maintained by Ambulatory Care Services include (a) to (d); 2. Privileges of clinical staff performing specific procedures is available at point of care; 3. Record of the procedure/operation performed and documented in the patient's medical record details the following: a. Procedure/ operations performed;					

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and d) Standard drug administration records are maintained and regulations relating to the control of drugs are followed; 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	b. Date and time;						
	c. Type of anaesthesia;						
	d. Personnel involved in the procedure/ operation;						
	e. Procedure / operative findings;						
	f. Record of accountable items used in operating theatre;						
	g. The dressings applied and drainage systems inserted (where applicable);						
	h. Postoperative orders; and						
	i. Operation note/ clinical note.						
CRITERION 12B.1.1.12 (NEW)							
The Head of Services shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	1. Documented and approved BCP for unanticipated situations;						
	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a) Likelihood; b) Impact; c) Assigned ownership, and d) Risk treatment.						
	3. Clear actions and staff responsibilities during disruption.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	4. Record of drills or tests, with follow-up actions, if conducted.						
	5. Review of Risk Register.						

STANDARD 12B.1.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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; and 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	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;					
		d. Involvement in performance measurement of the relevant services provided to the Facility.					

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and ix) Personnel provided by the external services who shall be bound by the rules and regulations applicable to the staff of the Facility.							

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TOPIC 12B.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD 12B.2.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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 certification/registration;						
	2. Appointment/assignment letter of responsibility; and						
	3. Training and competency records is dated, verified and signed by supervisor.						
CRITERION 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	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;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; the criteria for individual procedures are documented in detail; e.g. competency records/log books(e-logbook), 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 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;	4. Recommendations from peer/referee;						
	5. Availability of the list of specialised procedures requiring credentialing and privileging; and						
	6. Availability of list of specialised procedures specific to the disciplines performed by medical officers; competency records/log books.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.							
CRITERION 12B.2.1.3							
The authority, responsibilities and accountabilities of the Head of Ophthalmology Ambulatory Care Services/Centre are clearly delineated and documented.	1. Appointment/assignment letter for Head of Service; and						
	2. Description of duties and responsibilities.						
CRITERION 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 / MA(PPP)/ JM in one (1) operating room, including at least one (1) post basic ophthalmology trained	1. Number of staff and qualification should commensurate with workload;						
	2. Staffing pattern;						
	3. Duty roster is dated and authorised; and						
	4. Census and statistics.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
nurse in each operating room. The number of nurses/ MA(PPP) shall be commensurate with the number of operating rooms							
CRITERION 12B.2.1.5							
There are written and dated specific job descriptions for all categories of staff that include staff. 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; and 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; and						
	4. The job description is acknowledged by the staff and signed by the Head of Service and dated.						
CRITERION 12B.2.1.6 (CORE)							
Clinical staff performs within the privileges conferred	1. Verification of procedures e.g. phacoemulsification, etc performed by individual at point of care within the awarded privileging rights with evidence of:						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	a. List of procedures privileged; and						
	b. Clinical notes and operative notes.						
CRITERION 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.	1. Staff personal records include:						
	a. Staff biodata;						
	b. Qualification and experience;						
	c. Evidence of current registration;						
	d. Training record/ training schedule						
	e. Competency record and privileging;						
	f. Leave record; and						
	g. Confidentiality agreement.						
CRITERION 12B.2.1.8 (CORE) (NEW)							
There is a structured orientation programme for all newly appointed, contracted and outsourced staff to the Services that include but not limited to the following: General	1. Policy requiring all new staff to attend a structured orientation programme;						
	2. There is Services orientation programme with relevant topics not limited to topics covered from (a) to (q); and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
a) Vision and mission of the Facility; b) Organization chart and reporting structure of the Facility; c) Environment and facility safety policies and procedures including sustainability practices; d) Infection control policies and procedures; e) Policies for performance management, patient safety (IPSG/MPSG) and risk management; f) Ethical practices and code of conduct including medicolegal awareness; g) Management of aggression, violence and harassment; and h) Patient and family rights. <u>Services</u> i) Goals, objectives and organizational structure of Services; j) Policies and procedures relevant to Services; k) Working instructions for patient care; and l) Service continuity plan for Service in response to internal and external disasters. <u>Job-specific</u> m) Explanation of particular duties and functions;	3. Attendance list.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
n) Explanation of the methods of assigning clinical care and the standards of clinical practice; o) Handover communication; p) Training in basic/advanced life support techniques; and q) Technology and equipment use including artificial intelligence, digital care and robotics.							
CRITERION 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.	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; and						
	4. Certificate of attendance/degree/post basic training.						
CRITERION 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	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; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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in their current positions and future advancement.	4. Training module.						
CRITERION 12B.2.1.11							
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.	1. Performance appraisal for medical practitioners (including consultants, specialists and medical officer) and staff is completed upon probationary period and as an annual exercise.						

STANDARD 12B.2.2 (NEW)

The Ambulatory Care services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the nursing staff, ensuring a safe and healthy work environment.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 12.2.2.1 (CORE) (NEW)							
The Ambulatory Care Services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being. a) A health-promoting environment, e.g., stress management, burn out, staff engagement opportunities, workload monitoring, management of work life balance, healthy, lifestyle programmes e.g. Workplace Wellness Programs,	1. The promotion of staff well-being may involve the following:						
	a. Evidence of a health promoting environment e.g., workplace wellness programme;						
	b. Evidence of proper supervision of staff; and						
	c. Evidence of staff appraisal programme with feedback on underperformance.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Community-Based Health Initiatives; b) Staff shall be provided with appropriate supervision, support, and advice e.g., mentor mentee program; and c) There shall be clear procedures for the effective management of underperformance e.g., feedback on performance review or performance appraisal report.							
CRITERION 12.2.2.2 (CORE) (NEW)							
The ambulatory care services shall establish a safe mechanism for ambulatory care staff to express grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety.	1. Ambulatory care staff suggestions and grievance reporting and processing mechanisms are available;						
	2. The resolution of workplace issues may involve the following:						
	a. Measures and evidence of ambulatory care staff protection including whistleblowers against violence, bullying, and harassment e.g., awareness campaigns, anonymous reporting channel, Whistleblower policy; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	b. Documented policies and procedures for violence activation and ambulatory care staff protection.						
CRITERION 12.2.2.3 (NEW)							
A system shall be created to gather staff feedback about their workplace experience such as burnout which shall be analysed and used to make improvements that enhance the work environment, staff satisfaction, and organisation culture.	1. Staff feedback (e.g., minutes of sessions or staff satisfactions survey):						
	a. Evidence of action or improvement taken.						
CRITERION 12.2.2.4 (NEW)							
The ambulatory care services shall track sick leave and staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning	1. Evidence that workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments. The results shall be used to create focused actions that improve staff well-being, solve problems, and help retain employees.						

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TOPIC 12B.3
POLICIES AND PROCEDURES

STANDARD 12B.3.1
DEVELOPMENT, DERIVATION AND DOCUMENTATION
Documented policies and procedures shall reflect current knowledge and 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.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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, clinical practice guidelines and Patients and Family Rights. 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.	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; and						
	4. The policies and procedures are endorsed and dated.						
CRITERION 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.	1. Minutes of committee meetings on development and revision on policies and procedures;						
	2. Minutes of meeting with evidence of cross reference with the other departments/Centre; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	3. Documented cross departmental/centre policies.						
CRITERION 12B.3.1.3							
Current policies and procedures are communicated to all staff.	1. Training and briefing on the current policies and procedures/Minutes of meetings; and						
	2. Circulation list and acknowledgement.						
CRITERION 12B.3.1.4 (CORE)							
There is evidence of compliance with policies and procedures including patients and family rights.	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; and						
	d. Practices in line with established policies and procedures.						
CRITERION 12B.3.1.5							
Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.	1. Copies of relevant policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.						
CRITERION 12B.3.1.6 (CORE)							

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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	1. Documented policies that address (a) to (l).					

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and 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							
CRITERION 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.	1. Credential and privileging of registered medical practitioner carry out procedural sedation;						
	2. Policy on management of deep sedation; and						
	3. Anaesthesiologist is present throughout the deep sedation procedure as observed during survey on site.						
CRITERION 12B.3.1.8							
	1. Patient information pamphlet;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
All patients and their relatives shall be given essential information pertaining to the procedure which include: m) The patient's pre-admission responsibilities and preparation; n) The functioning of the ophthalmology ambulatory care services; o) Type of anaesthesia and post anaesthetic effects; p) Provision for after-hours contact and emergency care; q) The patient's post-discharge responsibilities/instructions; and r) Follow-up instruction.	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					
CRITERION 12B.3.1.9							
The policies and procedures for management of emergency patients shall include arrangement for transfer of patients, where necessary.	1. Policies and procedures on management of emergency patients include:						
		a. Patient transfer; and					
		b. Verification on compliance as per patient notes on transfer arrangement.					
	2. Policy on Code Blue						
	3. Verification on compliance as per patient notes on transfer arrangement.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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; and						
	3. Contents in the referral letter are appropriately written and includes acceptance of the patient by the referred facility, name of receiving person.						
CRITERION 12B.3.1.11							
a) There are policies and procedures for the Theatre Sterilising Supply Unit (TSSU). The policies and procedures shall include the following: b) The patient's pre-admission responsibilities and preparation; c) Receiving and decontamination processes (disassembling, washing, cleaning and disinfection); d) Packaging process (inspection, functionality check and packing); e) Sterilisation process;	1. Policies and procedures that address TSSU processes but not limited to items (a) to (k) are available.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
f) Validation processes; g) Sterile storage and distribution; h) Traceability and product recall; i) Services provided to other healthcare facilities; j) Environmental control (storage condition, effective maintenance of sterility); k) Shelf life of sterile items appropriate to utilisation (turnover time); l) Safety practices in TSSU; and m) Utilisation of "flash" autoclave in operating theatre and clinics.							
CRITERION 12B.3.1.12							
There shall be no reprocessing of any single-use medical-surgical instruments, equipment or supplies.	1. Policy on 'No reprocessing' of any single-use medical surgical instruments, equipment or supplies.						
	2. Compliance with 'No reprocessing' policy.						
CRITERION 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.	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; and						
	3. Steriliser records, e.g. number of cycles.						

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STANDARD 12B.3.2
PATIENT AND FAMILY RIGHTS
The Ophthalmology Ambulatory Care Services is responsible for providing processes that support patient and family rights from the point of accessing care.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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	1. There is documented Patient and Family Rights Policy as identified in the relevant laws and regulations that address items (a) to (o); and						
	2. Compliance with the Patient and Family Rights Policy as observed on site.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and o) Access to health promotion information to facilitate their treatment in the Facility/Centre.							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Patient's religion and beliefs are identified; and						
	2. Orientation checklist addresses the needs of the patient.						
CRITERION 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.	1. Policy on patient's possessions and records; and						
	2. On-site observation on compliance with the above policy.						
CRITERION 12B.3.2.4 (CORE)							
The Facility/Centre has a policy on risk identification and implementation of safety measures to protect patients from injury.	1. Policy on risk identification; and						
	2. Risk identification strategies, e.g. security guard, closed circuit television (CCTV), fall prevention.						
CRITERION 12B.3.2.5							
The Facility/Centre ensures patient health information as confidential.	1. Policy on safeguarding of patient information;						
	2. Policy on release of patient's medical record;						
	3. Code of conduct of medical records staff; and						
	4. The following systems as observed on site:						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	a. Secured health information system with restricted access levels;						
	b. Restricted access to Medical Records Unit; and						
	c. System for recording and monitoring movement of medical records.						
CRITERION 12B.3.2.6							
Patients are informed of their rights to voice their complaints and the grievance mechanism	1. Policy on grievance mechanism;						
	2. Patient orientation checklist;						
	3. Patient Charter; and						
	4. Brochure on Patient and Family Rights.						

STANDARD 12B.3.3
HEALTH INFORMATION MANAGEMENT SYSTEM
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.
An accurate patient's medical record is maintained to facilitate optimal patient care and allow for evaluation of the care provided.
***Personal Data Protection Act, PDPA 2013**

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 12B.3.3.1							
A single record for every patient is maintained with integrated recording system by healthcare providers.	1. A single record system is implemented; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.	2. Integrated records are practiced.						
CRITERION 12B.3.3.2							
There is a system for patient identification, cross referencing and a filing system that allows rapid retrieval of records.	1. Policies and procedures for patient identification, cross referencing and a filing system that allows rapid retrieval of records						
CRITERION 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.	1. Policy for safeguarding the information in the record against breach of confidentiality, loss, damage, or use by unauthorised personnel is in place; and						
	2. Guidelines for management of medical records, electronic information system security and user access control policies (paper based and electronic information systems); and						
	3. Mechanisms are in place to support Facility/Centre -wide and HIMS functions even in case of unexpected failure or disruption.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 12B.3.3.4 (CORE)							
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.	1. Signed consent forms. (The procedure is only performed after the consent taken.); and						
	2. Evidence of documentation in medical records (explanation given at the time of taking consent)						
CRITERION 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; and h) Surgeon's name and signature including name of assistant where applicable	1. Sampling of medical records to verify operative report addressing items (a) to (h).						
CRITERION 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	1. Samplings of medical records and verify the notes containing anaesthetic report addressing items (a) to (h).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and h) Name and signature of attending anaesthetist.							
CRITERION 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).	1. Policy and guidelines on the retention of medical records;						
	2. Records on medical records disposal; and						
	3. On-site observation on storage of medical records.						

STANDARD 12B.3.4
PREVENTION AND CONTROL OF INFECTION
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 12B.3.4.1							
A designated staff who has training in prevention and control of	1. Designated nurse with training in prevention and control of						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.	infection oversee the prevention and control infection measures;						
	2. Surveillance reports and records;						
	3. Environmental inspection records; and						
	4. On-site training records conducted by staff in-charge.						
CRITERION 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; and i) Protocol for post-exposure management for infectious disease and for assignment of infected staff.	1. Where appropriate, records are kept on actions taken which include items (a) to (i).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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; and f) Practice of standard and additional precautions.	1. There is evidence of items (a) to (f) being implemented.						
CRITERION 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).	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; and						
	5. National and local antibiotic guidelines.						
CRITERION 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.	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; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	3. Single use anaesthetic items are disposed after each use.						
CRITERION 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; and b) Proposed new equipment intended for patient care conforms to accepted infection control standards.	1. Records on input PIC and nurse in-charge of infection control for (a) and (b) where applicable.						
CRITERION 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.	1. Minutes of Infection Control Committee meeting;						
	2. Reports on;						
		a. Healthcare associated infection rates;					
		b. Surveillance data on infections and infection potentials; and					
		c. Implementation of infection control policies					
	3. Records on pertinent findings submitted to the appropriate source for necessary action to be taken.						

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STANDARD 12B.3.5
PHARMACY SERVICES

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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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 keeping accurate and accessible records on medicines supplied and administered to inpatients (ward/ daycare) and outpatients; d) Administered to inpatients and outpatients; e) Administering of medicines brought into the facility/ centre by patients; f) Administering of medicines by patients, where appropriate; g) Access to patients' medical records, where appropriate; h) Abbreviations where used are in accordance with an approved list and this list is	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; and						
	6. Drug reconciliation policy.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
endorsed by the Person In Charge (PIC); and i) Reconstitution, storage, transportation and administration of cytotoxic drugs (where applicable).							
CRITERION 12B.3.5.2							
There are documented policies and procedures on prescribing medication that state:staff education; 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; and c) Drugs dispensed and administered are based on the original of the medical practitioner's order. Drug orders are not transcribed.	1. Policies and procedures include (a) to (c) are available;						
	2. Security access is established for electronic prescribing;						
	3. Records on original prescription; and						
	4. Updated sample of doctors' signature for manual prescribing.						
CRITERION 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	1. Appropriate committee to discuss the ADR incidents;						
	2. Policies and procedures are in place for ADR reporting; and						
	3. Sample of ADR reports and dissemination of findings.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Committee/appropriate internal committee (where applicable).							
CRITERION 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.to the	1. Standard operating procedures for reporting of medication erro;						
	2. Completed medication error report; and						
	3. Evidence of corrective and preventive action plan taken and dissemination of findings.						

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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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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	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 and clear exit route						
	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						

DISTRIBUTION

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	care area for safe care. (e.g. defibrillators, emergency cart, hand washing facilities etc)						
CRITERION 12B.4.1.2							
Existing facilities shall take cognisance of the safety of staff and patients.	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; and						
	4. Equipment should have scheduled planned preventive maintenance (PPM).						
CRITERION 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.	1. Appropriate telecommunication modalities available for daily operation and during emergencies.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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	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; and						
	3. Medical device registration certificate from Medical Device Authority.						
CRITERION 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.	1. Planned Preventive Maintenance records such as schedule, stickers, etc.;						
	2. Planned Replacement Programme where applicable;						
	3. Complaint records; and						
	4. Asset inventory.						
CRITERION 12B.4.1.6							
Emergency biomedical equipment is thoroughly tested as a routine, e.g. defibrillators are discharged and output checked every day or	1. Records on regular inspection and checking biomedical equipment (electrocardiogram strips for defibrillator); and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
after each use, and the results recorded.	2. Policy and schedule on checking biomedical equipment.						
CRITERION 12B.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	1. User training records;						
	2. Competency assessment record;						
	3. Letter of authorisation; and						
	4. List of staff trained and competent to operate specialised equipment.						
CRITERION 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.	1. Equipment are being replaced and upgraded to meet current standard of care and advancement in technology in a planned and systematic manner.						
CRITERION 12B.4.1.9 (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care.						

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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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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; and e) Adequate provision is made for patient comfort	1. The Ophthalmology Outpatient Services address (a) to (e) 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;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	i. Adequate patient personal use items, e.g. Wheelchair, etc; and						
	j. Adequate waiting area, rest rooms, refreshments, reading material and parking space.						
CRITERION 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; and c) Performance of various tests.	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; and						
	d. List of procedures done.						
CRITERION 12B.4.2.3							
When an optometrist is present, examination room shall be set up according to standards to enable precise measurement.	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; and						
	2. Observation on-site during survey.						

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STANDARD 12B.4.3
FACILITIES AND EQUIPMENT FOR DAYCARE WARD
Adequate facilities and equipment shall be available to provide safe and effective patient care in the day care ward.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 12B.4.3.1							
Facilities are suitably located to facilitate easy access and to provide an atmosphere of user, environmental and 'disabled' friendly.	1. Floor plan indicates accessibility and patient and user friendly;						
	2. Feedback from patient satisfaction survey; and						
	3. Incident reporting relating to facilities if any.						
CRITERION 12B.4.3.2							
Equipment, both for emergency and non-emergency usage, shall be appropriate to the level of care	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; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	6. Scheduled checking of items in emergency trolley.						
CRITERION 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; and d) Emergency biomedical equipment, e.g. Defibrillator is checked at least once a day or after each use and the result is recorded	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; and						
	4. Defibrillator calibration testing record.						

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STANDARD 12B.4.4
OPERATING THEATRE FOR OPTHALMOLOGY AMBULATORY CARE SERVICES
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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; and i) there is plan for providing improved staff facilities when the Facility undergoes	1. The design and layout of the operating suite provide adequate space and includes features as listed in (a) to (i); and						
	2. Adequate recovery bay is available for post-operative cases.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
refurbishment or redevelopment if any of the above are deemed inadequate							
CRITERION 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	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 (18ºC-22ºC) 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; and						
	7. Log book on medical gas monitoring.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and l) Colour coding for electrical outlets shall be according to international standards.							
CRITERION 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	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%.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
with current Malaysian Standards; and 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.							
CRITERION 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; and d) Appropriate personal protective equipment are provided in the presence of biohazards or laser procedures.	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; and 3. Warning signs is placed outside the operating theatre if laser is in use.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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); and d) Emergency and resuscitation equipment and supplies; with clearly defined instructions on how to operate the equipment and there is evidence that staff	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; and						
	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.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
are trained to use the equipment							
CRITERION 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 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	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; and						
	3. Adequate number of nurses according to norms and suitably qualified and trained to assist in anaesthetic emergencies.						
CRITERION 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.	1. Documented evidence of maintenance records on all equipment used in the delivery of anaesthesia; and						
	2. System on respond to breakdown repair.						
CRITERION 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,	1. Compliance to standard guidelines on monitoring of anaesthetised patients, i.e. “Safety Standards for Anaesthesia and Recovery”.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
capnometry and others as may be necessary.							
CRITERION 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 antihypoxic devices, alarms for oxygen pressure failure, and ventilator disconnect alarms.	1. Availability of general anaesthesia (GA) machines with the required safety features.						
CRITERION 12B.4.4.10							
Anaesthetic waste gases and vapours shall be scavenged.	1. Evidence of functional Anaesthetic Gas Scavenging Systems.						
CRITERION 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.	1. Availability of emergency alert.						

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STANDARD 12B.4.5
THEATRE STERILISING SUPPLY UNIT (TTSU)
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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) Receiving of unsterile supplies: 1) 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) Assembling and Packaging: 1) Facilities for assembling, packaging supplies and equipment shall	2. 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 facilitate the activities of sterilisation supply services;						
	c. Compliance with Infection Control Policies and practices;						
	d. Appropriate work benches at assembling and packaging area.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
have hand hygiene facilities, work counter (a non-porous material work benches) or its equivalent as required by types and volume of items. iii) Sterilisation: 1) 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; and e) Suitably planned layout of work benches and equipment.							
CRITERION 12B.4.5.2							
All sterilising systems (e.g. mechanical and chemical system) are maintained in accordance with statutory regulations.	1. Manual and log book of mechanical sterilising system; and 2. Planned preventive maintenance schedule and records.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Appropriate equipment to match complexity of the facility's services such as:						
	a. Washer disinfector;						
	b. Ultrasonic washer;						
	c. Dryer;						
	d. Heat sealing equipment; and						
	e. Rapid biological test incubator.						
CRITERION 12B.4.5.4 (CORE)							
Validation on sterilisation process using mechanical, chemical and biological tests are conducted and results monitored and recorded accordingly.	1. Performance of relevant tests and results:						
	a. Mechanical test results records;						
	b. Chemical test result records; and						
	c. Biological test result records.						
	2. Records on deviations if any and corrective and preventive actions taken; and						
	3. Relevant efficacy test records considering mechanical aspects, chemical aspects, temperature and time.						

STANDARD 12B.4.6
LINEN SERVICES
The Linen Services include the supply and delivery of clean linen and the collection and off site washing of dirty and soiled linen.
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.
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 12B.4.6.1 (CORE)							
The patient shall be in clean linen throughout the procedure	1. Policy on linen supply; and						
	2. Patients have clean linen as evidenced on-site.						
CRITERION 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.	1. Policy on management of soiled linen;						
	2. Soiled linen is collected in dedicated colour coded linen bag as observed on inspection; and						
	3. Adequate supply of alginate bag for contaminated linen.						
CRITERION 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.	1. Policy on handling contaminated linen;						
	2. Use of colour coded linen bag for different types of linen; and						
	3. Use of alginate bag for contaminated linen as evidenced on site.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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; and b) Physical appearance and condition of linen.	1. Policies and Procedures on Linen Services that address but not limited to items (a) to (b) are available.						
CRITERION 12B.4.6.5							
Clean linen is transported and stored separately from soiled linen.	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; and						
	4. Dedicated clean linen storage area.						

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TOPIC 12B.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 12B.5.1
The Head of Ophthalmology Ambulatory Care Services shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Ophthalmology Ambulatory Care Services. The Head of Ophthalmology Ambulatory Care Services shall ensure compliance to monitoring of specific performance indicators.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Plans for patient safety, quality improvement and risk management.						
CRITERION 12B.5.1.2							
There are periodical 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; and g) Innovation	1. Planned performance improvement activities include (a) to (g);						
	2. Records on performance improvement activities;						
	3. Minutes of performance improvement meetings;						
	4. Performance improvement studies;						
	5. Mortality and morbidity audits with remedial actions; and						
	6. Records on innovation if available.						
CRITERION 12B.5.1.3							

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.	1. Minutes of meetings;						
	2. Letter of assignment of responsibilities; and						
	3. Job description.						
CRITERION 12.5.1.4							
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.	1. System for incident reporting is in place, which include:						
	a. Training of staff;						
	b. Policy on incident reporting;						
	c. Methodology of incident reporting; and						
	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; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	8. Feedback given to staff regarding incident reporting.						
CRITERION 12B.5.1.5 (CORE)							
The Ophthalmologist Ambulatory Care Services/Centre shall address Patient Safety Goals to prevent potential errors from occurring. a) World Health Organization (WHO) Global Patient Safety Challenges: i) Identify patient correctly; ii) Improve effective communication; iii) Improve the safety of high-alert medications; iv) Ensure correct-site, correct-procedure, correct-patient surgery; v) Reduce the risk of healthcare associated infections; and vi) Reduce the risk of patient harm resulting from fall. b) World Health Organization (WHO) Patient Safety Solutions: i) Look-Alike, Sound-Alike Medication Names; ii) Patient Identification; iii) Communication During Patient Hand-Overs; iv) Performance of Correct Procedure at Correct Body Site; v) Single Use of Injection Devices; and	1. Report on implementation of WHO Global Patient Safety Challenges & Patient Safety Solutions and Malaysian Patient Safety Goals.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
vi) Improved Hand Hygiene to Prevent Healthcare Associated Infections. c) Malaysian Patient Safety Goals i) To implement Clinical Governance; ii) To implement the WHO's 1st Global Patient Safety Challenge: "Clean Care is Safer Care"; iii) To implement the WHO's 2nd Global Patient Safety Challenge: "Safe Surgery Saves Lives"; iv) To improve the accuracy of patient identification; v) To ensure medication safety; vi) To improve clinical communication by implementing critical value programme; vii) To reduce patient fall; and viii) To implement an Incident Reporting and Learning System.							
CRITERION 12B.5.1.6 (CORE)							
There is tracking and trending of specific performance indicators of the following: a) Percentage of infectious endophthalmitis following cataract surgery (Target: < 0.2%, 2 cases per 1000 operations)	1. Specific performance indicators monitored;						
	2. Records on tracking and trending analysis; and						
	3. Remedial measures taken where appropriate.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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: >90%)							
CRITERION 12B.5.1.7 (NEW)							
The Services participates in the Facility's safety culture assessment. The results are utilized by Service leadership to inform and guide efforts to improve the culture of safety within the Service.	1. Safety Culture Survey for staff.						
CRITERION 12B.5.1.8							
Feedback on results of safety and performance improvement activities are regularly communicated to the staff to promote transparency, shared learning, and active engagement in improvement initiatives.	1. Results on safety and performance improvement activities are accessible to staff through education sessions, meetings and digital communications.						
CRITERION 12B.5.1.9							
Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.	1. Documentation on performance improvement activities and performance indicators.						
	2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						

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TOPIC 12B.6
SPECIAL REQUIREMENTS

STANDARD 12B.6.1
WASTE MANAGEMENT
The disposal of domestic, clinical and recycled wastes is carried out in accordance with legislation requirements of the Department of Environment and local authority.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 12B.6.1.1							
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; and 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	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; and						
	5. Contract for clinical waste disposal.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and f) Availability of hand washing facilities in storage area.							
CRITERION 12B.6.1.2							
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.	1. Cytotoxic wastes are properly labelled and not mixed with other wastes;						
	2. Appropriate storage facilities for cytotoxic wastes; and						
	3. Spillage kits.						
CRITERION 12B.6.1.3							
Staff that handle chemicals and healthcare facility wastes need to be trained on proper handling and disposal of such wastes.	1. Records on staff training.						
CRITERION 12.6.1.4							
Staff shall wear appropriate personal protective equipment when handling hazardous materials.	1. Staff and contractors wear appropriate personal protective equipment.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 12B.6.1.5							
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; and c) The clinical waste store shall be refrigerated if the wastes are stored for more than 24 hours	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;						
	3. Records on tracking and trending analysis; and						
	4. Remedial measures taken where appropriate.						

STANDARD 12B.6.2
FIRE SAFETY

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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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	1. Building drawing approved by Fire Authority for buildings built after 1990; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
buildings built after 1990, 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	2. Continuous Monitoring Information System (CMIS) is functional and linked to the fire station where applicable.						
CRITERION 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. **Note:** Refer to Fire Service Act 1988	1. Annual fire inspection report by Fire Authority;						
	2. Current Fire Safety Certificate is available for buildings built after 1990; and						
	3. Facility's report on rectification of recommendations by Fire Authority where required.						
CRITERION 12B.6.2.3							
Firefighting 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.	1. Fire extinguishers have valid inspection certificates;						
	2. Testing of fire extinguishers; and						
	3. Maintenance records.						
CRITERION 12B.6.2.4							
There are clear signages to indicate the location of firefighting equipment and general instructions	1. Signages indicating firefighting equipment are clearly visible.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
to use the equipment during emergency.							
CRITERION 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.	1. Fire exit routes are unobstructed.						
CRITERION 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	1. KELUAR / EXIT signs are:						
	a. Clearly visible;						
	b. Functional; and						
	c. Adequate.						
CRITERION 12B.6.2.7							
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.	1. Current evacuation plans are available; and						
	2. Clear signage to assembly areas.						
CRITERION 12B.6.2.8							
There are adequate "No Smoking" signs posted at all entrances to the Facility.	1. “No Smoking” signs are:						
	a. Visible;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	b. Adequate;						
	c. Placed at all entrances to the Facility.						
CRITERION 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.	1. Assignment letter.						
	2. Training records.						
	3. Minutes of fire safety meetings.						
CRITERION 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.	1. Records and reports on annual fire drills; and						
	2. Staff attendance list.						
CRITERION 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 firefighting equipment, fire evacuation procedures and evacuation of non-ambulant patients.	1. Staff awareness on fire and evacuation plan; and						
	2. Records on training of key assigned personnel and staff on specific aspects of fire safety.						

STANDARD 12B.6.3

DISASTER MANAGEMENT

There shall be a disaster management system that supports safe practice and a safe environment.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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; and j) Disease outbreak.	1. Internal Disaster Plan that includes 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; and						
	5. Reports on the Internal Disaster Drill that carry out once a year.						
CRITERION 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.	1. Specified colour codes for internal disaster.						

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SERVICE SUMMARY	
OVERALL RATING :	-
OVERALL RISK :	-

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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.

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TOPIC 13.1
ORGANISATION AND MANAGEMENT

STANDARD 13.1.1
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.

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.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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 are measurable in line with the Facility statements available, endorsed and dated;						
	3. Evidence of planned reviews of the above statements (at least once in 3 years or in the event of any major changes);						
	4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc.); and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.						
CRITERION 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; 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; and 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 Critical Care Unit, consultants, medical practitioners and staff of the Critical Care Unit;						
	2. Organisation chart of the service is endorsed, dated and accessible; and						
	3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).						
CRITERION 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	1. Minutes are accessible, disseminated and acknowledged by the staff;						
	2. Attendance list of members with adequate representation of the services;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.	3. Frequency of meetings as scheduled; and						
	4. Discussion and resolutions are implemented.						
CRITERION 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	1. Minutes of Facility-wide management meeting;						
	2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc.) for the service; and						
	3. Approved budget and resources.						
CRITERION 13.1.1.5							
The Head of each CCS is involved in the appointment and/OR assignment of the staff.	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; and						
	5. Duty roster.						
CRITERION 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. For	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;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.	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.						
CRITERION 13.1.1.7							
The Governing Body shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	1. Documented and approved BCP for unanticipated situations;						
	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment.						
	3. Clear actions and staff responsibilities during disruption;						
	4. Record of drills or tests, with follow-up actions, if conducted; and						
	5. Review of Risk Register.						

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TOPIC 13.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD 13.2.1
The Critical Care Services (CCS) are appropriately and adequately staffed to achieve their goals and objectives.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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; and 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.	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; and						
	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.						
CRITERION 13.2.1.2							
The authority, responsibilities and accountabilities of the Head of	1. Appointment/assignment letter for Head of Service; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Critical Care Services are clearly delineated and documented.	2. Description of duties and responsibilities.						
CRITERION 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: d) 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; e) A nursing sister in-charge of the unit is appointed and has qualification in post basic nursing appropriate for the unit; f) A nursing staff with post basic appropriate for the unit is in-charge of the unit each shift; g) All nurses shall be trained in intensive care nursing; h) Nurse/patient ratio of 1:1 for ventilated patient; i) Nurse/patient ratio of 1:2 for non-ventilated patient; j) A biomedical technician is available on 24 hour basis; k) Cleaning personnel familiar with ICU environment and infection control/ environmental cleaning protocols (Ref: Consensus Statement on Infection	1. Number of staff and qualification should commensurate with workload and includes items (a) to (j); 2. Staffing pattern; 3. Duty roster of medical officer trained in anaesthesia/ICU and nursing staff; 4. Duty roster of physiotherapist, pharmacist, and dietitian in Level 2 and 3 Care; and 5. Census and statistics.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Control Measures in ICU) are available on 24 hour basis; l) Level 2 and 3 Care, pharmacist,physiotherapist and dietitian are available during working hours; and m) For level 3 ICU Physiotherapist ideally available 24 hours.							
CRITERION 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; and 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; and 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; and						
	4. The job description is acknowledged by the staff and signed by the Head of Service and dated.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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;						
	e. Competency record and privileging;						
	f. Leave record; and						
	g. Confidentiality agreement;						
CRITERION 13.2.1.6							
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.	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; and						
	4. Training module.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 13.2.1.7							
There are continuing education activities for staff including medical practitioner to pursue professional interests and to prepare for current and future changes in practice.	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; and						
	4. Certificate of attendance/degree/post basic training.						
CRITERION 13.2.1.8 (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; and b) A system of ongoing re-certification.	1. Staff training records and yearly training plan; and						
	2. Certification in basic life support, advanced life support and recertification.						
CRITERION 13.2.1.9							
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.	1. Performance appraisal for staff including medical practitioners is completed upon probationary period and as an annual exercise.						

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STANDARD 13.2.2 (NEW)
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.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 13.2.2.1 (CORE)							
There is a structured orientation programme for all newly appointed, contracted and outsourced staff to the Services that include but not limited to the following: <u>General</u> a) Vision and mission of the Facility; b) Organisation chart and reporting structure of the Facility; c) Environment and facility safety policies and procedures including sustainability practices; d) Infection control policies and procedures; e) Policies for performance management, patient safety (IPSG/MPSG) and risk management; f) Ethical practices and code of conduct including medicolegal awareness; g) Management of aggression, violence and harassment; and h) Patient and family rights. <u>Services</u>	1. Policy requiring all new staff to attend a structured orientation programme;						
	2. There is Services orientation programme with relevant topics not limited to topics covered from (a) to (q); and						
	3. Attendance list.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
i) Goals, objectives and organisational structure of Services; j) Policies and procedures relevant to Services; k) Working instructions for patient care; l) Service continuity plan for Services in response to internal and external disasters; and m) Explanation of particular duties and functions. <u>Job-specific</u> n) Explanation of the methods of assigning clinical care and the standards of clinical practice; o) Handover communication; p) Training in basic/advanced life support techniques; and q) Technology and equipment use including artificial intelligence, digital care and robotics.							

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STANDARD 13.2.3 (NEW)

The Critical Care Services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the staff, ensuring a safe and healthy work environment.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 13.2.3.1 (CORE)							
The Critical Care Services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being. a) A health-promoting environment, e.g., stress management, burn out, staff engagement opportunities, workload monitoring, management of work life balance, healthy, lifestyle programmes e.g. Workplace Wellness Programs, Community-Based Health Initiatives; b) Staff shall be provided with appropriate supervision, support, and advice e.g., mentor mentee program; and c) There shall be clear procedures for the effective management of underperformance e.g., feedback on performance review or performance appraisal report.	1. The promotion of staff well-being may involve the following:						
		a. Evidence of a health promoting environment e.g. workplace wellness programme;					
		b. Evidence of proper supervision of staff; and					
		c. Evidence of staff appraisal programme with feedback on underperformance.					

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 13.2.3.2 (CORE)						
The Critical Care Services shall establish a safe mechanism for Critical Care Services staff to express grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety.	1. Critical Care staff suggestions and grievance reporting and processing mechanisms are available; 2. The resolution of workplace issues may involve the following: a. Measures and evidence of Critical Care Services staff protection including whistleblowers against violence, bullying, and harassment e.g., awareness campaigns, anonymous reporting channel, Whistleblower policy; and b. Documented policies and procedures for violence activation and staff protection.					
CRITERION 13.2.3.3 (NEW)						
A system shall be created to gather staff feedback about their workplace experience such as burnout which shall be analysed and used to make improvements that enhance the work environment, staff satisfaction, and organisation culture.	1. Staff feedback (e.g., minutes of sessions or staff satisfactions survey); a. Evidence of action or improvement taken.					
CRITERION 13.2.3.4 (NEW)						
The Critical Care services shall track sick leave and Critical Care staff turnover, using this data to improve wellbeing, engagement,	1. Evidence that workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked					

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
and retention. Data analysis shall support better workforce planning	for trends and compared across departments. The results shall be used to create focused actions that improve Critical Care staff well-being, solve problems, and help retain Critical Care employees.						

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TOPIC 13.3
POLICIES AND PROCEDURES

STANDARD 13.3.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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, current standard practices and Patients and Family Rights. 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.	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; and						
	4. The policies and procedures are endorsed and dated.						
CRITERION 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	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; and						
	3. Documented cross departmental policies.						

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applicable. These policies and procedures are consistent with current international standards for critical care services.							
CRITERION 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: d) Operational policy; e) Admission, discharge and referral policy; f) Visitation policy; g) Credentialing and privileging on special procedures, e.g. Mechanical ventilation, renal replacement therapy; h) Clinical management protocol, e.g. Weaning from mechanical ventilation, thromboprophylaxis, etc i) Drug administration; j) Procedural policy, e.g. Central line catheterisation; k) Antibiotic policy; l) Infection control; m) Needle stick injury; n) Transport of patients; o) Withholding and withdrawal of therapy; advance care plan 2024); and p) Organ donation;	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.						
CRITERION 13.3.1.4 (CORE)							
Policies and procedures are integrated in the care of patients	1. Compliance with policies and procedures through:						

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incorporating but not limited to the following: a) Admission process; b) Pre procedure/investigation assessment; c) Intra procedure/ investigation protocols; d) Post procedure/investigation care; e) Transition of care process; f) Prevention & control of infection; g) Environment of care for patients; and h) Discharge process There is evidence of compliance with policies and procedures on various types of patients.	a. Interview of staff on practices; b. Verify with observation on practices; c. Practices in line with established policies and procedures.						
CRITERION 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.	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; and d. Practices in line with evidence-based guidelines						
CRITERION 13.3.1.6							
Current policies and procedures are communicated to all staff	1. Training and briefing on the current policies and procedures/Minutes of meetings; and						

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	2. Circulation and acknowledgement.						
CRITERION 13.3.1.7							
Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.						

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TOPIC 13.4
FACILITIES AND EQUIPMENT

STANDARD 13.4.1
There are appropriate and adequate physical facilities and equipment for the efficient operations of the critical care services.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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.						
CRITERION 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.	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; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	5. Absence of overcrowding.						
CRITERION 13.4.1.3							
The immediate physical environment of the patient is as unobtrusive and as aesthetically pleasing as possible.	1. Physical environment of the patient is unobtrusive as observed on- site.						
CRITERION 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; a) Hand-drying facility, e.g. Disposable paper towels; b) Alcohol-based hand rub per bed; c) Separate clean and dirty utility rooms; d) Endotracheal suctioning via a closed system or a single use disposable catheter.	1. Infection control facilities in each unit include (a) to (e) as observed on site.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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 2.5m2 and control of airflow; b) Level 2 Care: Negative pressure isolation room; and 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).	1. Isolation rooms appropriate to the level of care provided are available						
CRITERION 13.4.1.6							
There are separate areas for the sanitation and storage of equipment.	1. Separate areas for sanitation and storage of equipment as observed upon site inspection.						
CRITERION 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; and d) Waiting area for relatives.	1. Presence of facilities for relatives and staff include (a) to (d) as observed on site						
CRITERION 13.4.1.8 (CORE)							
The Critical Care Services shall have 24-hour access to on-site laboratory services such as:	1. Blood gas machine is available and functional in the unit;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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 1 hours for review and action; and d) Culture and Gram-stain results are available 24 hours per day.	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; and						
	5. Availability of culture results 24 hours per day.						
CRITERION 13.4.1.9 (CORE)							
The Critical Care Services shall have 24-hour access to Radiology/Diagnostic Imaging Services and blood bank services.	1. Evidence from interview of staff/records on availability of 24-hour access to Radiology/Diagnostic Imaging Services and blood bank services.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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; and h) Minimum 3 compressed air outlets per bed for Level 3 Care.	1. The number of vacuum outlets, oxygen, compressed air outlets and suction facilities commensurate with the complexities of services provided.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 13.4.1.11 (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.	1. All the beds are functional as per standard requirement						
CRITERION 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), noninvasive pressure, temperature and pulse oximetry; and 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.	1. All the above listed facilities and equipment for the level of care provided are available as in (a) to (b) and functional.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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;	1. All the above facilities and equipment are available and functional and include systems and facilities as listed in (a) to (p);						
	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; and						
	b. Level 3 Care: the invasive ventilators should have the advanced modes of mechanical ventilation, alarm systems and battery back-up.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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 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; 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; and							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
p) For Level 3 Care, renal replacement therapy services are available 24 hours per day.							
CRITERION 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	1. Emergency and life support equipment are available and functional as required; and						
	2. Resuscitation trolley (1 per 8 beds), defibrillator and equipment to manage difficult airway.						
CRITERION 13.4.1.15							
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); and						
	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.						
CRITERION 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.	1. Records on advisory service on safe use and maintenance of biomedical device and electrical installations; and						
	2. User training records.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Planned Preventive Maintenance records such as schedule, stickers, etc;						
	2. Planned Replacement Programme where applicable;						
	3. Complaint records; and						
	4. Asset inventory.						
CRITERION 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.	1. User training records;						
	2. Competency assessment record;						
	3. Letter of authorisation; and						
	4. List of staff trained and competent to operate specialised equipment.						
CRITERION 13.4.1.19 (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promotes environmentally sustainable care.						

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TOPIC 13.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 13.5.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 13.5.1.1							
There are periodical 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; and g) Innovation	1. Planned performance improvement activities include (a) to (g);						
	2. Records on performance improvement activities;						
	3. Minutes of performance improvement meetings;						
	4. Performance improvement studies;						
	5. Mortality and morbidity audits with remedial actions; and						
	6. Records on innovation if available.						
CRITERION 13.5.1.2							
The Head of Critical Care Services has assigned the	1. Minutes of meetings.						

responsibilities for planning, monitoring and managing safety and performance improvement to appropriate individual/personnel within the respective services.	2. Letter of assignment of responsibilities.						
	3. Job description.						
CRITERION 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.	1. System for incident reporting is in place, which include:						
	a. Training of staff;						
	b. Policy on incident reporting; and						
	c. Methodology of incident reporting.						
	2. Register/records of incidents;						
	3. Completed incident reports;						
	4. Root Cause Analysis;						
	5. Corrective and preventive action plans;						
	6. Remedial measure;						
	7. Minutes of meetings;						
	8. Acknowledgment by Head of Service and PIC/Hospital Director; and						
	9. Feedback given to staff regarding incident reporting.						
CRITERION 13.5.1.4 (CORE)							
The Critical Care Services has Clinical Risk Management	1. Risk Management Programme;						

Programme that provides an appropriate peer group structure for performing the safety and performance improvement activities to accomplish clinical care evaluation. h) The medical practitioners undertake clinical reviews of all risk assessments, incident reports, audits, safety and performance improvement activities: i) Multidisciplinary committees within the Services; and ii) In a variety of purpose-specific committees, such as mortality and morbidity, blood transfusion and infection control. i) Whatever structure is utilised, provision is made for review and analysis of the clinical work of each individual clinical service, unit or function.	2. Minutes of meetings; and 3. Relevant reports and documents, e.g. clinical audit reports, incident reports, mortality and morbidity review reports, etc.						
CRITERION 13.5.1.5 (CORE)							
There is tracking and trending of specific performance indicators not limited to but at least 5 of the following: j) Rate of pressure ulcers (Target: < 3%); k) Rate of unplanned extubation (Target: <5%); l) Rate of Ventilator Associated Pneumonia (VAP)	1. Specific performance indicators monitored; 2. Records on tracking and trending analysis; and 3. Remedial measures taken where appropriate.						

(Target: < 10 per 1000 ventilator days); m) Rate of catheter related blood stream infection (Target: < 5 per 1000 catheter days); n) Compliance rate to hand hygiene in accordance to the national requirement; and o) For Level 2 & 3 Care, standardized mortality ratio and benchmarking with other units.							
CRITERION 13.5.1.6 (NEW)							
The Services participates in the Facility's safety culture assessment. The results are utilized by Service leadership to inform and guide efforts to improve the culture of safety within the Service.	1. Safety Culture Survey for staff.						
CRITERION 13.5.1.7							
Feedback on the results of safety and performance improvement activities are regularly communicated to the staff to promote transparency, shared learning, and active engagement in improvement initiatives.	1. Results on safety and performance improvement activities are accessible to staff through education sessions, meetings and digital communications.						
CRITERION 13.5.1.8							
Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.	1. Documentation on performance improvement activities and performance indicators.						
	2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						

SERVICE SUMMARY	
OVERALL RATING :	-
OVERALL RISK :	-

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SERVICE STANDARD 13A : CRITICAL CARE SERVICES – SCN / NICU / PICU / PHDU UNIT

PREAMBLE

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.

The units that fall within this category are:

a) Paediatric Critical Care Services:
- ***1) Paediatric Intensive Care Units (PICU)***
- ***2) Paediatric High Dependency Unit (PHDU)***

b) Neonatal Critical Care Services
- ***1) Special Care Nursery (SCN)***
- ***2) Neonatal Intensive Care Units (NICU)***

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).

<u>Neonatal Levels of Care</u>

a) Level I (Neonatal care in the postnatal wards)

Provide care for the following infants placed together with their mothers and regarded as inpatients:
- ***1) Stable term newborn infants***
- ***2) Infants born 35-37 weeks' gestation who remain physiologically stable***
- ***3) Infants receiving phototherapy for mild neonatal jaundice, on glucose monitoring, for completion of antibiotics***

b) Level II (Special care nursery)

Level II facilities and capabilities should take into consideration geographical constraints.

Provide care for the following infants:
- ***1) Born at > 32 weeks' gestation and weight > 1500g who have physiologic immaturity.***
- ***2) Moderately ill infants with problems that are expected to resolve rapidly and are not anticipated to need subspecialty services on an urgent basis.***
- ***3) Infants with mild to moderate respiratory illness on non-invasive ventilation (CPAP or HFNC). Conventional ventilation may be provided for a brief duration until transfer to a NICU.***
- ***4) Infants with management of common neonatal conditions e.g. neonatal jaundice, Infants with risk of sepsis.***
- ***5) Post intensive care convalescing infants***
- ***6) Infants with chronic NIV or oxygen dependency.***

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7) *Infants needing surgical nursing.*

Level II facilities and capabilities should take into consideration geographical constraints.

c) ***Level III (NICU)***
Provide sustained life support for the following infants:
1) ***Born before 32 weeks gestation and weight less than 1500g***
2) ***Infants born at all gestational ages and birth weights with critical illness requiring sustained life support, such as:***
   i) ***Respiratory support including invasive ventilation (conventional and high-frequency ventilation), non-invasive ventilation (CPAP, HFNC), inhaled nitric oxide***
   ii) ***Therapeutic hypothermia for neonatal encephalopathy***
3) ***Infants require access to paediatric medical subspecialists, paediatric surgeons, paediatric anaesthesiologists, paediatric ophthalmologists, etc.***

d) ***Level IV (Regional NICU)***
Level III capabilities plus:
1) ***Born before 32 weeks gestation and weight less than 1500g***
2) ***Infants born at all gestational ages and birth weights with critical illness requiring sustained life support, such as:***
   i) ***Respiratory support including invasive ventilation (conventional and high-frequency ventilation), non-invasive ventilation (CPAP, HFNC), inhaled nitric oxide***
   ii) ***Therapeutic hypothermia for neonatal encephalopathy***
3) ***Infants require access to paediatric medical subspecialists, paediatric surgeons, paediatric anaesthesiologists, paediatric ophthalmologists, etc.***
4) ***Located within an institution with the capability to provide on-site surgical repair of complex congenital or acquired conditions.***
5) ***Has a range of paediatric medical subspecialists, paediatric surgical subspecialists, and paediatric anaesthesiologists at the site.***

(Based on current Paediatric Services Operational Policy)

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TOPIC 13A.1
ORGANISATION AND MANAGEMENT

STANDARD 13A.1.1
The SCN/NICU/PICU/PHDU shall be organised and administered to provide safe, efficient, and effective critical care services in accordance with the identified level of care. 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.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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 are measurable in line with the Facility statements available, endorsed and dated;						
	3. Evidence of planned reviews of the above statements (at least once in 3 years or in the event of any major changes);						
	4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc); and						
	5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.						
CRITERION 13A.1.1.2 (CORE)							
There is an organisation chart which:	1. Clearly delineated current organisation chart with line of functions and reporting						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
a) Provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head of the Paediatric or 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; and d) Is revised when there is a major change in any of the following: i) Organisation; ii) Functions; iii) Reporting relationships; and iv) Staffing patterns.	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; and						
	3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).						
CRITERION 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.	1. Minutes are accessible, disseminated and acknowledged by the staff.						
	2. Attendance list of members with adequate representation of the service.						
	3. Frequency of meetings as scheduled.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).						
CRITERION 13A.1.1.4							
The Head of each of the Paediatric or Neonatal Critical Care Services is involved in the planning, justification and management, of the budget and resource utilisation of the services.	1. Minutes of Facility-wide management meeting; and						
	2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service.						
CRITERION 13A.1.1.5							
The Head of a Paediatric or Neonatal CCS is involved in the appointment and/ or assignment of the staff.	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; and						
	5. Duty roster.						
CRITERION 13A.1.1.6							
Appropriate statistics and records shall be maintained in relation to the provision of Paediatric or Neonatal Critical Care Services	1. Records are available but not limited to the following:						
	a. Workload/census;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
and used for managing the services and patient care.	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 relevant to each specific critical care;						
	g. Hand washing records, Central Line-Associated Bloodstream Infection (CLABSI) rates, nosocomial infection rates and mortality rates; and						
	h. Mortality/ Morbidity Meetings						
	2. Statistics are used for managing services and patient care.						
CRITERION 13A.1.1.7							
The Head of Services shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and	1. Documented and approved BCP for unanticipated situations;						
	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
alternative arrangements to continue care.	3. Clear actions and staff responsibilities during disruption;						
	4. Record of drills or tests, with follow-up actions, if conducted; and						
	5. Review of Risk Register.						

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TOPIC 13A.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD 13A.2.1
The Paediatric and Neonatal Critical Care Services are appropriately and adequately staffed and directed to achieve their goals and objectives.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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; and						
	6. Deployment/assignment according to staff speciality.						
CRITERION 13A.2.1.2							
The authority, responsibilities and accountabilities of the Head of Paediatric or Neonatal CriticaL Care Services is clearly delineated and documented.	1. Appointment/assignment letter for Head of Service; and						
	2. Description of duties and responsibilities						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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 statutory and accepted norms.	1. Number of staff and qualification should commensurate with workload;						
	2. Duty roster;						
	3. Census and statistics;						
	4. Staffing pattern;						
	a. Paediatric and Neonatal Intensive Care 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; and						
	b. High Dependency Care: i. Paediatric - A nurse should not have responsibility for the care of more than two (2) patients; and ii. Neonatal - Special Care Nursery (Level II) A staff nurse should not have responsibility for the care of more than four (4) patients: (Based on Refer Paediatric Services						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	Operational Policy 2024 MOH/P/PAK/535.24(GU)-e						
CRITERION 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.	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; and						
	4. The job description is acknowledged by the staff and signed by the Head of Service and dated.						
CRITERION 13A.2.1.5							
Personnel records on training, staff development, leave and others are maintained for every staff. **Note:**	1. Staff personal records include:						
	a. Staff biodata;						
	b. Qualification and experience;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Staff personal record may be kept in Human Resource Department as per Facility policy.	c. Evidence of current registration (Annual Practising Certificate, National Specialist Register, etc);						
	d. Training record;						
	e. Competency record and privileging;						
	f. Leave record; and						
	g. Confidentiality agreement;						
CRITERION 13A.2.1.6							
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.	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; and						
	4. Training module.						
CRITERION 13A.2.1.7							
There are continuing education activities for staff including medical practitioners to pursue professional interests and to prepare for current and future changes in practice.	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						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	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; and						
	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.						
CRITERION 13A.2.1.8 (CORE)							
Clinical staff including medical practitioners working in the Paediatric Critical Care and Neonatal Critical Care Services have: a) Specific specialised skills such as cardiopulmonary resuscitation (CPR), Basic Life Support (BLS), Neonatal Resuscitation Programme (NRP), Malaysian Paediatric Life Support (MPLS), Advanced Paediatric Life Support (APLS); and b) A system of ongoing re-certification.	1. Medical and nursing staff who work in the Paediatric and Neonatal Critical Care setting shall be proficient in resuscitation of paediatric or neonatal patients;						
	2. Certification in specific cardiopulmonary resuscitation life support, Neonatal Resuscitation Programme (NRP), Malaysian Paediatric Life Support (MPLS), Advanced Paediatric Life Support (APLS) and re-certification; and						
	3. Schedule of life support training for new and current staff						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 13A.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.	1. Performance appraisal for staff including medical practitioners is completed upon probationary period and as an annual exercise.						

STANDARD 13.2.2 (NEW)
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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 13.2.2.1 (CORE)							
There is a structured orientation programme for all newly appointed, contracted and outsourced staff to the Services that include but not limited to the following: General a) Vision and mission of the Facility; b) Organisation chart and reporting structure of the Facility; c) Environment and facility safety policies and procedures including sustainability practices; d) Infection control policies and procedures;	1. Policy requiring all new staff to attend a structured orientation programme;						
	2. There is Services orientation programme with relevant topics not limited to topics covered from (a) to (q); and						
	3. Attendance list.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
e) Policies for performance management, patient safety (IPSG/MPSG) and risk management; f) Ethical practices and code of conduct including medicolegal awareness; g) Management of aggression, violence and harassment; and h) Patient and family rights. <u>Services</u> i) Goals, objectives and organisational structure of Services; j) Policies and procedures relevant to Services; k) Working instructions for patient care; and l) Service continuity plan for Service in response to internal and external disasters. <u>Job-specific</u> m) Explanation of particular duties and functions; n) Explanation of the methods of assigning clinical care and the standards of clinical practice; o) Handover communication; p) Training in basic/advanced life support techniques; and q) Technology and equipment use including artificial							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
intelligence, digital care and robotics.							

STANDARD 13A.2.3 (NEW)

The Critical Care Services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the staff, ensuring a safe and healthy work environment.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 13A.2.3.1 (CORE)							
The Critical Care Services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being. a) A health-promoting environment, e.g., stress management, burn out, staff engagement opportunities, workload monitoring, management of work life balance, healthy, lifestyle programmes e.g. Workplace Wellness Programs, Community-Based Health Initiatives; b) Staff shall be provided with appropriate supervision, support, and advice e.g., mentor mentee program; and c) There shall be clear procedures for the effective management of underperformance e.g., feedback on performance	1. The promotion of staff well-being may involve the following:						
	a. Evidence of a health promoting environment e.g., workplace wellness programme;						
	b. Evidence of proper supervision of staff; and						
	c. Evidence of staff appraisal programme with feedback on underperformance.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
review or performance appraisal report.							
CRITERION 13.2.3.2 (CORE)							
The Critical Care Services shall establish a safe mechanism for Critical Care Services staff to express grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety.	1. Critical Care staff suggestions and grievance reporting and processing mechanisms are available						
	2. The resolution of workplace issues may involve the following:						
	a. Measures and evidence of surgical staff protection including whistleblowers against violence, bullying, and harassment e.g., awareness campaigns, anonymous reporting channel, Whistleblower policy; and						
	b. Documented policies and procedures for violence activation and critical care services staff protection.						
CRITERION 13.2.3.3 (NEW)							
A system shall be created to gather staff feedback about their workplace experience such as burnout which shall be analysed and used to make improvements that enhance the work environment, staff satisfaction, and organisation culture.	1. Staff feedback (e.g., minutes of sessions or staff satisfactions survey);						
	a. Evidence of action or improvement taken.						
CRITERION 13.2.3.4 (NEW)							
The Critical Care services shall track sick leave and Critical Care	1. Evidence that workforce data (e.g., sickness absence, early retirements						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning	due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments. The results shall be used to create focused actions that improve Critical Care staff well-being, solve problems, and help retain Critical Care employees.						

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TOPIC 13A.3
POLICIES AND PROCEDURES

STANDARD 13A.3.1
There are written and dated policies and procedures for all the activities of Paediatric and Neonatal 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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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, current standard practices and Patients and Family Rights. 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	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, Protocol (latest edition), Private Healthcare Facilities and Services Act 1998 (PHFSA), its Regulation (2019), Ministry of Health Guidelines, Centers for Disease Control and Prevention (CDC) 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						

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There is a mechanism for and evidence of a periodic review at least once in every three years. **Note:** 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.	scope of Paediatric and Neonatal Critical Care Services; 6. Evidence of periodic review of policies and procedures; and 7. The policies and procedures are endorsed and dated.						
CRITERION 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.	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 4. Attendance list of the stakeholders in the meeting or committee.						
CRITERION 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	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;						

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 in paediatric and neonatal critical care unit ; b) Specifications as to who may perform special procedures, under what circumstances and under what degree of supervision eg. special procedures in this context may include intubation, tracheostomy, insertion of central lines. , Other invasive procedures; including all forms of mechanical 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;	3. Review of patient notes regarding drug administration eg. usage of antibiotics, thromboprophylaxis;						
	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; and						
	9. Policy on Baby Friendly Hospital Initiative.						

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; and m) Mechanical ventilation (if absolutely necessary) outside Intensive Care Unit.							
CRITERION 13A.3.1.4 (CORE)							
Policies and procedures are integrated in the care of patients incorporating but not limited to following: a) Admission process; b) Pre procedure/investigation assessment; c) Intra procedure/ investigation protocols; d) Post procedure/investigation care; e) Transition of care process; f) Prevention & control of infection; g) Environment of care for patients; and h) Discharge process There is evidence of compliance with policies and procedures on various types of patients.	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.						

CRITERION 13A.3.1.5							
Current policies and procedures are communicated to all staff.	1. Training and briefing on the current policies and procedures;						
	2. Circulation list and acknowledgement of staff that have read the policies; and						
	3. Attendance list/ Minutes of meeting.						
CRITERION 13A.3.1.6							
Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, Medical By-Laws and statutory requirements are accessible to staff.	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, Medical By-Laws and statutory requirements are accessible on-site for staff reference.						
CRITERION 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/PHDU) 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,	1. The NICU, PICU and PHDU should have paediatric medical subspecialists 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 Service;						
	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; and						
	b. Nursing Staff who support NICU/PICU/ PHDU must have training appropriate to their role in the care of sick paediatric/						

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 ie. medical practitioners and nursing staff, medical assistant pharmacist, physiotherapist, dietitian and social worker); support for postgraduate education for clinical staff.	neonate patients and support for their parents.						
	5. Other team members may include (but not limited to):						
	a. Pharmacists;						
	b. Physiotherapists;						
	c. Dietitians;						
	d. Infection control staff; and						
	e. Social welfare workers.						

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TOPIC 13A.4
FACILITIES AND EQUIPMENT

STANDARD 13A.4.1
There are appropriate and adequate physical facilities and equipment for the efficient operations of the Paediatric / Neonatal Critical Care Services SCN/NICU/PICU/PHDU.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 13A.4.1.1							
The Paediatric and Neonatal Critical Care Services shall be provided in a discrete area close to areas which have the greatest requirements for its services.	1. The Paediatric and Neonatal Critical Care Services should be situated in a discrete area with easy access to operating theatres, Labour Delivery Suite, etc; and						
	2. The unit should be easily accessible with clear signage.						
CRITERION 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.	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; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	6. Accessibility of critical equipment and consumables at all times.						
CRITERION 13.4.1.3							
The immediate physical environment of the patient is as unobtrusive and as aesthetically pleasing as possible.	1. Physical environment of the patient is unobtrusive as observed on- site.						
CRITERION 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; and e) Endotracheal suctioning via a closed system or a single use disposable catheter.	1. Infection control facilities in each unit include (a) to (e) as observed on site.						
CRITERION 13A.4.1.5							
There shall be provision for isolation of certain categories of patients, e.g. those with airborne infectious diseases.	1. Isolation rooms or areas appropriate to the level of care provided are available e.g., negative pressure isolation room; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	2. Area to cohort infected patients or contacts are made available if no designated rooms are provided.						
CRITERION 13A.4.1.6							
There are separate areas for the sanitation and storage of equipment.	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; and						
	b. Cleaning utility/holding room for storing used and contaminated material before its removal from the care area.						
CRITERION 13A.4.1.7							
There are facilities for patients, relatives and staff which include: a) Counselling room for parents or legal guardians; b) Rest room for staff; c) Changing rooms at relevant care areas where appropriate; and d) Waiting area for parents or legal guardians.	1. Presence of facilities for relatives and staff include (a) to (d) as observed on site.						
CRITERION 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	1. There is adequate space around each bed for routine and emergency care that meets regulatory requirements.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
routine and emergency care of the patient, and also to accommodate bulky equipment which may be needed and comply with the relevant regulatory requirements.							
CRITERION 13A.4.1.9 (CORE)							
The Paediatric and Neonatal Critical Care Services shall have 24-hour access to onsite 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.	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 or acknowledgement entered into the patient's Hospital Information System (HIMS) and plan of action documented;						
	5. Interview of staff regarding availability of culture results 24 hours per day; and						
	6. Laboratory Turnaround Time for Critical Care Services is the same throughout the 24 hours.						
CRITERION 13A.4.1.10 (CORE)							
The Paediatric and Neonatal Critical Care Services shall have 24-hour access to Radiology/Diagnostic Imaging Services and blood transfusion services.	1. Evidence from interview of staff/records on availability of 24-hour access to radiology/diagnostic imaging services and blood transfusion services.						
CRITERION 13A.4.1.11							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
The Paediatric and Neonatal Critical Care Services shall have support from all surgical, medical, allied health, and diagnostic specialties, together with appropriate clerical and other support staff.	1. Documented referral signed/ acknowledgement in HIMS and dated to respective units;						
	2. Response to the referral according to case-case basis;						
	3. Documented reply signed/ acknowledgement in HIMS and dated by respective units; and						
	4. Evidence of cross departmental referral where required as seen in patient's medical records/ HIMS.						
CRITERION 13A.4.1.12 (CORE)							
Each intensive care beds should have these equipment and facilities in place according to the current norms	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;						
	2. There should be a mixture of emergency and normal power for all electrical outlets per current regulatory requirement; and						
	3. Availability of positive pressure ventilation equipment e.g., ambubags/ T-piece resuscitators (for neonates) at each intensive bed.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. All the beds are functional as per standard requirement.						
CRITERION 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 current norms)	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.						
CRITERION 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) Air conditioning and/or specialised airflow patterns which comply with regulatory requirements; c) A medical alert 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;	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; and						
	4. Temperature for the medication and vaccine refrigerator is kept between 2°C – 8°C with logbook of daily temperatures.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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 current norms							
CRITERION 13A.4.1.16 (CORE)							
All other emergency and life support equipment are readily accessible and functional.	1. Emergency and life support equipment are available and functional as required:						
	a. Emergency trolley; and						
	b. Basic resuscitation items with suction available at each patient care area as observed upon inspection e.g. Positive pressure ventilation equipment e.g., ambubags / t-piece resuscitators (for neonates) at each intensive bed.						
CRITERION 13A.4.1.17							
There is documented evidence that equipment complies with relevant national/international	1. Testing, commissioning and calibration records (certificates or stickers); and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
standards and current statutory requirements.	2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM) as evidence of compliance to the relevant standards and Acts.						
CRITERION 13A.4.1.18							
Expert advice concerning the safe use of, and maintenance for all biomedical devices and electrical installations are readily available. Documentation of safety testing is provided on a regular basis to the unit head.	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.						
CRITERION 13A.4.1.19 (CORE)							
There is evidence that the facilities and equipment have a comprehensive maintenance programme such as planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.	1. Planned Preventive Maintenance records such as schedule, stickers, etc;						
	2. Planned Replacement Programme where applicable;						
	3. Complaint records; and						
	4. Asset inventory.						
CRITERION 13A.4.1.20 (CORE)							
Where specialised equipment is used, there is evidence that only	1. User training records;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
staff who are trained and authorised by the Facility operate such equipment.	2. Competency assessment record;						
	3. Letter of authorisation; and						
	4. List of staff trained and competent to operate specialised equipment.						
CRITERION 13A.4.1.21 (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care.						

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TOPIC 13A.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 13A.5.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 13A.5.1.1							
There are periodical 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; and g) Innovation.	1. Planned performance improvement activities include (a) to (g).						
	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.						
CRITERION 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	1. Minutes of meetings.						
	2. Letter of assignment of responsibilities.						
	3. Job description.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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)	1. System for incident reporting is in place, which include:						
	a. Training of staff;						
	b. Policy on incident reporting; and						
	c. Methodology of incident reporting.						
	2. Register/records of incidents;						
	3. Completed incident reports;						
	4. Root Cause Analysis;						
	5. Corrective and preventive action plans;						
	6. Remedial measure;						
	7. Minutes of meetings; and						
	8. Acknowledgment by Head of Service and PIC/Hospital Director.						
CRITERION 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*	1. Name tags of the neonate should have at least 2 identifiers – Mother's full name and Hospital RN (Registered Number) or National Registration Identification Card;						
	2. Process of discharging baby from the ward at exit points e.g., Security						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Garis panduan Sistem Kawalan Keselamatan Bayi di Hospital-Hospital Kementerian Kesihatan Malaysia Edisi Kedua 2024 MOH/P/PAK/517.23(GU)-e) For paediatric critical care inpatients, identification tag with the patient's name and registration number shall be affixed to the patient's limb. (Refer Paediatric Services Operational Policy 2024 MOH/P/PAK/535.24(GU)-e	guard's counter following guidelines;						
	3. Identification banding for neonates at 1 body-site is compulsory but it is encouraged for 2 body sites; and						
	4. Name tags of the paediatric critical care patient should have at least 2 identifiers – Patient's full name and Hospital RN (Registered Number) or National Registration Identification Card						
CRITERION 13A.5.1.5							
The Paediatric and Neonatal 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; and ii) In a variety of purpose-specific committees, such as mortality and	1. Risk Management Programme;						
	2. Minutes of meetings; and						
	3. Relevant reports and documents, e.g. clinical audit reports, incident reports, mortality and morbidity review reports, etc.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.							
CRITERION 13A.5.1.6							
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 Policies and Procedures on Infection Prevention and Control 2019 b) rate of ventilator-associated pneumonia (VAP) c) percentage of survival of inborn all livebirths with birthweight between 1000-1499g (Refer Technical Specifications Clinical Services Quality Indicators (Clisqi) Medical Programme 2025) d) Report of mortality/morbidity audits/meetings being conducted in the unit with documentation of cases discussed	1. Specific performance indicators monitored; 2. Records on tracking and trending analysis; and 3. Remedial measures taken where appropriate.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 13A.5.1.7 (NEW)							
The Services participates in the Facility's safety culture assessment. The results are utilized by Service leadership to inform and guide efforts to improve the culture of safety within the Service.	1. Safety Culture Survey for staff.						
CRITERION 13A.5.1.8							
Feedback on the results of safety and performance improvement activities are regularly communicated to the staff to promote transparency, shared learning, and active engagement in improvement initiatives.	1. Results on safety and performance improvement activities are accessible to staff through education sessions, meetings and digital communications.						
CRITERION 13A.5.1.9							
Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.	1. Documentation on performance improvement activities and performance indicators; and						
	2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						
CRITERION 13A.5.1.10							
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).	1. Documentation on training of emergency or contingency plan;						
	2. Attendance list;						
	3. Evidence of practice drills e.g. fire drills; and						
	4. Scheduling of drills in the organization's annual plan.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 13A.5.1.11							
Validation process e.g., 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	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:						
	a. Reports on organization performance e.g. KPI;						
	b. Reports on compliance or conformance of the organization e.g. Incident reports;						
	c. Documentation of any remedial measures being carried;						
	d. Corrective and preventive action plans in place; and						
	e. 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 and conformance eg. SIRIM for ISO, Ministry of Health for KPI						

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SERVICE SUMMARY	
OVERALL RATING :	-
OVERALL RISK :	-

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SERVICE STANDARD 13B: CRITICAL CARE SERVICES – LABOUR/DELIVERY SERVICES

PREAMBLE

The Labour and Delivery Services are provided in discrete areas within the healthcare facility involving special facilities and speciality trained staff for the management of mothers in the first, second and third stages of labour as well as care of the newborn.

The Labour and Delivery Services require specialised nursing care and monitoring. The Nursing Services standards as in Service Standards No: 4 of this Standards of Accreditation shall also apply to these services.

Most High Dependency Units for obstetric patients are located within the Labour Delivery Suite complex.

TOPIC 13B.1
ORGANISATION AND MANAGEMENT

STANDARD 13B.1.1

The Labour and Delivery Services shall be organised and administered to provide comprehensive, safe, efficient, compassionate and effective services within a conducive environment.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services.

All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 13B.1.1.1							
Vision, Mission and values statements of the Facility are accessible. Strategic priorities and objectives that suit the scope of the Labour & Delivery 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 needed, with appropriate action plans implemented 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. Strategic priorities and operational objectives of the Labour & Delivery Services are measurable in line with the Facility statements available, endorsed and dated;						
	3. Evidence of planned reviews of the above statements (at least once in 3 years or in the event of any major changes); and						
	4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc.); and						

DISTRIBUTION

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	5. Achievement of goals and objectives are monitored, reviewed and revised with appropriate action plans implemented accordingly.						
CRITERION 13B.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 Labour & Delivery Services, consultants, medical practitioners and staff of the Labour & Delivery 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; and iv) Staffing patterns.	1. Clearly delineated current organisation chart with line of functions and reporting relationships the Person In Charge (PIC), Head of the Labour & Delivery Services, consultants, medical practitioners and staff of the Labour & Delivery Services;						
	2. Organisation chart of the service is endorsed, dated and accessible; and						
	3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).						
CRITERION 13B.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 Labour and Delivery 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 representation of the service,						
	3. Frequency of meetings as scheduled, and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	4. Discussion and resolutions are implemented.						
CRITERION 13B.1.1.4							
The Head of Labour and Delivery Services is involved in the planning, justification and management of the budget and resource utilisation of the services.	1. Minutes of Facility-wide management meeting;						
	2. Documented evidence on request for allocation of budget and staffing for the service; and						
	3. Approved budget, resources.						
CRITERION 13B.1.1.5							
The Head of Labour and Delivery Services is involved in the appointment and/or assignment of the staff.	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; and						
	5. Duty roster.						
CRITERION 13B.1.1.6							
Appropriate statistics and records shall be maintained in provision to the	1. Records are available but not limited to the following:						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Labour and Delivery Services and used for managing the services and patient care.	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; and						
	g. Customer feedback.						
CRITERION 13B.1.1.7							
The Head of Services shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	1. Documented and approved BCP for unanticipated situations;						
	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment.						
	3. Clear actions and staff responsibilities during disruption.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	4. Record of drills or tests, with follow-up actions, if conducted; and						
	5. Review of Risk Register.						

TOPIC 13B.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD 13B.2.1
The Labour and Delivery Services are appropriately and adequately staffed and directed to achieve their goals and objectives.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 13B.2.1.1						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
The Head and staff of the Labour and Delivery Services 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);						
	2. The Head and all trained staff shall have valid Annual Practising Certificate (APC);						
	3. 100% registered nurses in the Labour Delivery Suite are midwifery trained as required by the Midwives Act 1966 (Act 436);						
	4. Appointment/assignment letters;						
	5. Certification;						
	6. Training and competency records; and						
	7. Qualified Community Nurse can work in Labour Room & Maternity Ward.						
CRITERION 13B.2.1.2							
The authority, responsibilities and accountabilities of the Head of	1. Appointment/assignment letter for Head of Service; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Labour and Delivery Services are clearly delineated and documented.	2. Description of duties and responsibilities.						
CRITERION 13B.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 and grades of staff required shall be based on current regulatory requirements.	1. The number of staff and qualification should commensurate with workload, as per norm and regulatory requirements;						
	2. Staffing pattern;						
	3. Duty roster; and						
	4. Census and statistics.						
CRITERION 13B.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;	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; and						
	4. The job description is acknowledged by the staff and signed by the Head of Service and dated.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
iv) Qualifications required and privileges granted; v) Staffing patterns; and vi) Statutory Regulations. e) Administrative and clinical functions.							
CRITERION 13B.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 hospital policy.	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. Annual leave record;						
	g. Confidentiality agreement. (under governance)						
CRITERION 13B.2.1.6							
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.	1. Training needs assessment is carried out and gaps identified;						
	2. A staff development plan based on training needs assessment is available;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	3. Training schedule/calendar is in place;						
	4. Training module & training content; and						
	5. Registered Nurse midwife in the Labour and Delivery Services needs to show documented evidence of conducting at least five (5) vaginal deliveries per year or to maintain their competency.						
CRITERION 13B.2.1.7							
There are continuing education activities for staff including medical practitioners to pursue professional interests and to prepare for current and future changes in practice.	1. Training schedule/calendar is in place/ 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; and						
	4. Certificate of attendance/degree/post basic training.						
CRITERION 13B.2.1.8 (CORE)							
Clinical staff including medical practitioners working in the service have: a) Training in life support skills such as-Basic Life Support (BLS), Neonatal Resuscitation	1. Clinical staff including medical practitioners have the following:						
	a. Certificates in relevant emergency skills programmes;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Programme (NRP), Obstetric Life Saving Skills, etc; b) A system of ongoing re-certification.	b. Records on training and re-certification.						
CRITERION 13B.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.	1. Performance appraisal for staff including medical practitioners is completed upon probationary period and as an annual exercise.						

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STANDARD 13B.2.2 (NEW)
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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 13B.2.2.1							
There is a structured orientation programme for all newly appointed, contracted and outsourced staff to the Services that include but not limited to the following: <u>General</u> a) Vision and mission of the Facility; b) Organisation chart and reporting structure of the Facility; c) Environment and facility safety policies and procedures including sustainability practices; d) Infection control policies and procedures; e) Policies for performance management, patient safety (IPSG/MPSG) and risk management; f) Ethical practices and code of conduct including medicolegal awareness; g) Management of aggression, violence and harassment; and h) Patient and family rights. <u>Services</u>	1. Policy requiring all new staff to attend a structured orientation programme; 2. There is Services orientation programme with relevant topics not limited to topics covered from (a) to (q); and 3. Attendance list.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
i) Goals, objectives and organisational structure of Services; j) Policies and procedures relevant to Services; k) Working instructions for patient care; and l) Service continuity plan for Service in response to internal and external disasters. <u>Job-specific</u> m) Explanation of particular duties and functions n) Explanation of the methods of assigning clinical care and the standards of clinical practice o) Handover communication p) Training in basic/advanced life support techniques q) Technology and equipment use including artificial intelligence, digital care and robotics							

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STANDARD 13B.2.3 (NEW)

The Labour and Delivery Services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the surgical related staff, ensuring a safe and healthy work environment.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 13B.2.3.1 (CORE)							
The Labour and Delivery Services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being. a) A health-promoting environment, e.g., stress management, burn out, staff engagement opportunities, workload monitoring, management of work life balance, healthy, lifestyle programmes e.g. Workplace Wellness Programs, Community-Based Health Initiatives; b) Staff shall be provided with appropriate supervision, support, and advice e.g., mentor mentee program; and c) There shall be clear procedures for the effective management of underperformance e.g., feedback on performance review or performance appraisal report.	1. The promotion of staff well-being may involve the following:						
	a. Evidence of a health promoting environment e.g., workplace wellness programme.;						
	b. Evidence of proper supervision of staff; and						
	c. Evidence of staff appraisal programme with feedback on underperformance.						
CRITERION 13B.2.3.2 (CORE)							

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
The Labour and Delivery Services shall establish a safe mechanism for Labour and Delivery Services staff to express grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety.	1. Labour and Delivery staff suggestions and grievance reporting and processing mechanisms are available;						
	2. The resolution of workplace issues may involve the following:						
	a. Measures and evidence of Labour and Delivery staff protection including whistleblowers against violence, bullying, and harassment e.g., awareness campaigns, anonymous reporting channel, Whistleblower policy; and						
	b. Documented policies and procedures for violence activation and Labour and Delivery staff protection.						
CRITERION 13B.2.3.3 (NEW)							
A system shall be created to gather staff feedback about their workplace experience such as burnout which shall be analysed and used to make improvements that enhance the work environment, staff satisfaction, and organisation culture.	1. Staff feedback (e.g., minutes of sessions or staff satisfactions survey):						
	a. Evidence of action or improvement taken.						
CRITERION 13B.2.3.4							
The Labour and Delivery services shall track sick leave and Labour and Delivery staff turnover, using this data to	1. Evidence that workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning	checked for trends and compared across departments. The results shall be used to create focused actions that improve Labour and Delivery staff well-being, solve problems, and help retain Labour and Delivery employees.						

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TOPIC 13B.3
POLICIES & PROCEDURES

STANDARD 13B 3.1
There are written and dated policies and procedures for all the activities of the Labour and Delivery Services. These policies and procedures reflect current standards of Labour and Delivery Services practices, relevant regulations, statutory requirements, and the goals and objectives of the services.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 13B.3.1.1 (CORE)							
There are written policies and procedures for the Labour and Delivery Services which are consistent with the overall policies of the Facility, regulatory requirements, current standard practices and Patients and Family Rights. 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 ***Note:*** Standard policies and procedures, manuals etc. developed and issued by Central Bodies and/or Ministry of Health and other related Regulatory Bodies should act as a point of reference if direct adoption are not relevant to the level of services.	1. Documented policies and procedures, protocols, manuals and guidelines are available 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; and						
	5. Guidelines are reviewed and customised to meet the relevant needs and level of services of the facilities.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 13B.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 to ensure integrated care is implemented in the development of 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; and						
	3. Documented cross departmental policies.						
CRITERION 13B.3.1.3							
Current policies and procedures are communicated to all staff.	1. Training and briefing on the current policies and procedures/Minutes of meetings; and						
	2. Circulation list and acknowledgement.						
CRITERION 13B.3.1.4 (CORE)							
Policies and procedures are integrated in the care of surgical patients incorporating but not limited to following pathways: a) Admission process; b) Preoperative assessment; c) Intraoperative protocols; d) Post-anaesthesia care; e) Transition of care process;	1. Compliance with policies and procedures through:						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
f) Surgical site infection prevention; g) Day of surgery admission protocols; h) Environment of care for surgical patients; and i) Discharge process. There is evidence of compliance with policies and procedures. on various types of patients.	a. Interview of staff on practices;						
	b. Verify with observation on practices;						
	c. Results of audit on practices; and						
	d. Practices in line with established policies and procedures.						
CRITERION 13B.3.1.5							
Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site/workstation for staff reference						
CRITERION 13B.3.1.6							
The Labour and Delivery Services shall ensure a high level of medical and maternity care through the following policies: a) Medical practitioners shall have appropriate training in maternity care; b) Resident medical practitioner coverage on a 24-hour basis with access to consultant support at all times where no specialist is available on site;	1. Labour and Delivery Services ensure a high level of care through but not limited to elements as listed in (a) to (j); and						
	2. Verification of compliance through observation on-site						

DRAFT REPORT

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
c) Resident specialist medical coverage available at all times; d) Staffing level at registered nurse to patient ratio is appropriate to patient dependency needs; e) A nurse manager with post basic midwifery qualification and experience, and nursing staff with similar qualifications; f) 24-hour access to laboratory services; g) 24-hour access to imaging and other diagnostic facilities; h) Support available from all surgical, medical, allied health, and diagnostic specialities, together with appropriate clerical, scientific, and other support staff; i) Facilities for providing all aspects of appropriate maternity care monitoring and therapy; j) A team approach to patient care.							
CRITERION 13B.3.1.7							
Policies of the unit are appropriate to the Facility's scope of obstetrics care.	1. Policies of the unit appropriate to scope of obstetric services						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 13B.3.1.8 (CORE)							
The Labour and Delivery Services is a discrete service and have a policy and procedure manual and is kept up to date and is readily available to all staff. The manual shall include at least the following: a) Functions and authority of the unit managers, however named, with special emphasis on the working relationships that exist among the attending medical practitioners, obstetricians, nursing staff, the unit manager and/or other specialists; b) Specifications as to who may perform special procedures, under what circumstances and under what degree of supervision; special procedures in the event of an emergency the use of special equipment and supplies and where they are located; c) The assignment of responsibility for preventive and corrective maintenance programme, including procedures to follow in the event of the breakdown of essential equipment;	1. Policies and procedures manual is available and covers (a) to (s); and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
d) Prevention and control of infection and the capability of instituting isolation procedures; e) Visitors and access control; f) Core activities of the Labour and Delivery Services (LDS) which shall cover all the major aspects of patient care processes from admission to discharge and shall include but not limited to the following policies: i) Defined admissions, discharge, and referral policies; ii) Assessment; iii) Triaging; iv) Monitoring; v) Interventional procedures and therapies; vi) Obstetric emergencies and contingency plans; vii) Analgesia; viii) Instrumentation; ix) Normal deliveries and care of the newborn; (Tagging baby and mother) x) Staff supervision; (Injection Vit K & Hep B) xi) Handling and disposal of placenta; xii) Predischarge assessment of mother and baby; and	2. Verification of compliance upon observation on-site.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
xiii) Discharge advice; (all discipline involved in the patient's care) g) Procedures for formal audit and review; h) Reflect current standards of Labour and Delivery Services practices, relevant regulations and statutory requirements; i) Specifications as to who may perform special procedures/relevant care of the mother in labour and newborn; j) The provision and use of protective gear; k) Observation of universal precautions; l) Cord blood banking according to national guidelines or organisational guidelines; m) Stem cell therapy according to national guidelines; n) Reporting and management of occupational accidents specific to Labour and Delivery Services in line with the current Facility's policy; o) Storage, handling and use of dangerous drugs shall be in accordance with the Dangerous Drugs Act and Regulations (1952); p) Support for postgraduate education for clinical staff where applicable;							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
q) Provision for 24 hours security for mother and newborn; r) Correct baby identification; and s) Management of patients under police custody/prisoner.							
CRITERION 13B.3.1.9							
Policies and procedures are available to support the following initiatives: a) Mother-Friendly b) Baby-Friendly (Justify if not met)	1. Policies on mother and baby friendly initiatives; and						
	2. Verification of compliance upon observation on-site.						

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TOPIC 13B.4
FACILITIES AND EQUIPMENT

STANDARD 13B 4.1
There are appropriate and adequate physical facilities and equipment for the efficient operations of the Labour and Delivery Services.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 13B.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.	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; and						
	6. Non-slip flooring.						

DRAFT EDITION

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 13B.4.1.2 (CORE)							
The level of monitoring as well as intervention shall be appropriate to the scope of services provided by the unit.	1. Staff suggestions and grievance reporting and processing mechanisms are available;						
	2. Adequate numbers of:						
	a. Resuscitate; (O2 blended, SPO2 Machine, Low suction)						
	b. Transport incubator;						
	c. Cardiotocograph.						
	d. Access to ultrasound						
	e. New-born resuscitation area						
CRITERION 13B.4.1.3							
The space provided around each bed shall comply with relevant regulatory requirements 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	1. Design of the Delivery Unit should allow for easy access for routine and emergency care.						
CRITERION 13B.4.1.4							
	1. Adequate hand washing facilities						

DRAFT FOR REVIEW

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
There shall be adequate facilities for infection control in the unit, e.g., hand washing facilities.	2. Alcohol hand rubs						
	3. Access PPE (if necessary)						
	4. Facilities decontaminate exposed staff e.g., (Dedicated bathing area)						
CRITERION 13B.4.1.5							
There shall be provision for isolation of certain categories of patients, e.g. those with airborne infectious diseases.	1. Availability of negative pressure isolation room or a designated room with appropriate infection control measures.						
CRITERION 13B.4.1.6							
Facilities and equipment are appropriate to the design and function of the labour and delivery services and shall include the following: a) A system for Labour and Delivery Services personnel to summon additional staff in an emergency; b) Appropriate air conditioning which comply with regulatory requirements; c) Waiting area for relatives; these shall include areas with beverage facilities, toilets, and a separate area for distressed relatives and access to a prayer room; d) Adequate supplies of medications and intravenous fluids available 24 hours a day;	1. Facilities and equipment of the Labour Delivery Suite address but not limited to items (a) to (f).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
e) Separate areas for clean and dirty utilities and storage of equipment; f) Alternate emergency supply for lighting, gas and power sources or other appropriate mechanisms available to operate all life support systems including suction apparatus.							
CRITERION 13B.4.1.7							
There are adequate numbers of nitrous oxide, oxygen, compressed air, and suction facilities as well as properly grounded electrical outlets to every patient.	1. Adequate numbers of medical gas outlets and suction facilities;						
	2. Properly grounded electrical outlets; and						
	3. Verification of above facilities through on-site inspection.						
CRITERION 13B.4.1.8							
The delivery bed is readily adjustable to various therapeutic positions, easily moved for transport. It has a locking mechanism for a secure stationary position, cot sides and a removable headboard.	1. Appropriate type and numbers of delivery beds;						
	2. With ease of decontamination; and						
	3. If possible, the type of beds that have features to accommodate the different position of childbirth.						
CRITERION 13B.4.1.9							
Emergency and life support equipment are readily accessible and functional.	1. Availability of emergency trolley and defibrillator;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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	2. Infant resuscitaire available in the unit; and						
	3. Evidence of regular checks on functionality of life support equipment.						
CRITERION 13B.4.1.10							
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); and						
	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.						
CRITERION 13B.4.1.11							
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.	1. Facility Management Services are available 24 hours; and						
	2. Maintenance service records.						
CRITERION 13B.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	1. Planned Preventive Maintenance records such as schedule, stickers, etc;						
	2. Planned Replacement Programme where applicable;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
the facilities and equipment are in good working order.	3. Complaint records; and						
	4. Asset inventory.						
CRITERION 13B.4.1.13							
Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment, e.g. ultrasound, cardiotocograph and defibrillator	1. User training records;						
	2. Competency assessment record;						
	3. Letter of authorisation; and						
	4. List of staff trained and authorised to operate specialised equipment.						
CRITERION 13B.4.1.14							
There shall be designated blood storage facilities in the Labour and Delivery Services. Where such facilities do not exist, blood must be made available from the blood bank within 30 minutes.	1. Designated blood storage facilities evidenced.						
	2. Audited evidence of obtaining blood within 30 minutes upon request.						
CRITERION 13B.4.1.15 (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care.						

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TOPIC 13B.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 13B.5.1
The Head of Labour and Delivery Services shall ensure a consistent provision of quality and safe care by fostering a culture of continuous safety and performance improvement activities among the sfaff of the Labour and Delivery Services. The leadership shall provide the necessary resources, support, and oversight to sustain these activities and promote staff accountability and engagement in achieving the unit's quality and safety goals.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 13B.5.1.1							
There are periodical planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Labour and Delivery Services. The Service may consider the content of the WHO Global Patient Safety Action Plan to inform their approach on safety goals. The process includes: a) Define quality and safety goals; b) Planned activities; c) Data collection ; d) Monitoring and evaluation of the performance ; e) Action plan for improvement; f) Implementation of action plan; g) Re-evaluation for improvement; and h) Innovation	1. Safety goals are defined and documented;						
	2. Planned performance improvement activities include (a) to (h);						
	3. Records on performance improvement activities;						
	4. Minutes of performance improvement meetings;						
	5. Performance improvement studies;						
	6. Mortality and morbidity audits with remedial actions;						
	7. Records on innovation if available.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 13B.5.1.2							
The Head of Labour and Delivery Services assigns the responsibility for planning, monitoring and managing safety and performance improvement to designated individual/personnel within the services.	1. Minutes of meetings.						
	2. Letter of assignment of responsibilities.						
	3. Job description.						
CRITERION 13B.5.1.3							
The Head of the Labour and Delivery Services shall ensure that the staff are trained in incident reporting. All safety incidents, including near misses, are timely reported, investigated with lessons learned shared with staff and completed report forwarded to the Person In Charge (PIC) of the Facility. Safety incidents reported are systematically analysed using appropriate methodology such as Root Cause Analysis and action taken within the agreed time frame to prevent recurrence	1. System for safety incident reporting is in place, which include:						
		a. Training of staff;					
		b. Policy on safety incident reporting;					
		c. Methodology of safety incident reporting; and					
		d. Register/records of safety incidents.					
	2. Completed safety incident reports;						
	3. Investigative analysis (such as Root Cause Analysis);						
	4. Corrective and preventive action plans;						
	5. Remedial measure;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	6. Assessment of implemented action effectiveness;						
	7. Minutes of meetings;						
	8. Acknowledgment by Head of Service and PIC/Hospital Director; and						
	9. Feedback/lessons learned are shared with staff regarding incident reporting.						
CRITERION 13B.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) Incidence of massive Post-Partum Haemorrhage (PPH) of total deliveries should be less than 1% (exclusion criteria: placenta previa and adherence placenta); b) Complication rate from instrumental/vaginal deliveries: incidents of 3rd and 4th degree tears (Target: less than 10%); c) Maternal mortality (sentinel event); and d) Perinatal mortality. There is also tracking and trending of not limited to but at least one (1) outcome data to monitor how care, treatment, or other services provided improve the health status and wellbeing of	1. Specific performance indicators monitored;						
	2. Selected outcomes data monitored;						
	3. Records on tracking and trending analysis;						
	4. Remedial measures taken where appropriate; and						
	5. Records (e.g., meeting minutes) showing regular review of indicators performance or outcomes data results.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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patients. Examples of outcomes data are clinical results or patient-related outcome measures (PROMs). These indicators or outcomes are selected based on identified areas requiring improvement which is reviewed regularly for continued relevance. New indicators or outcomes may be selected to address current or emerging patient safety priorities.							
CRITERION 13B.5.1.5 (NEW)							
The Services participates in the Facility's safety culture assessment. The results are utilized by Service leadership to inform and guide efforts to improve the culture of safety within the Service.	1. Safety Culture Survey for staff						
CRITERION 13B.5.1.6							
Feedback on the results of safety and performance improvement activities is regularly communicated to the staff to promote transparency, shared learning, and active engagement in improvement initiatives.	1. Results of safety and performance improvement activities are accessible to staff through education sessions, meetings and digital communications.						
CRITERION 13B.5.1.7							
Safety and performance improvement activities are appropriately documented and kept, with safeguards in	1. Policy statement ensuring the confidentiality and anonymity of patients and staff involved in safety and performance improvement activities; and						

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place to preserve the confidentiality of patients and staff involved.	2. Evidence of de-identified data used in reports or discussions related to safety and performance improvement activities.						

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SERVICE SUMMARY	
OVERALL RATING :	
OVERALL RISK :	

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SERVICE STANDARD 13C: CHRONIC DIALYSIS TREATMENT STANDARDS

PREAMBLE

The Chronic Dialysis Treatment Standards are applicable to all haemodialysis facilities and services in public and private sectors including not-for-profit organisations. These facilities and services are either hospital-based or 'free-standing' and provide only chronic haemodialysis treatment.

The purpose of these standards is to ensure the delivery of safe medical practice whilst maintaining good quality service at the haemodialysis centres.

TOPIC 13C.1
ORGANISATION AND MANAGEMENT

STANDARD 13C.1.1
The haemodialysis centre should be organized to provide a high standard of haemodialysis treatment for the community in a safe manner. The haemodialysis centre shall be accessible and able to provide continued care for its patients.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 13C.1.1.1 (CORE)							
Vision, Mission and Values Statements of the haemodialysis centre are displayed. The goals and objectives of the 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.	1. Vision, Mission and Values Statements of the centre are displayed, endorsed and dated by the Governing Body/Person-In-Charge (PIC) of the centre;						
	2. Goals and objectives of the centre are available, endorsed and dated;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.	3. Documented evidence that these statements are communicated to all staff (orientation programme, minutes of meeting, etc); and						
	4. Documented evidence of achievements of goals and objectives are monitored, reviewed and revised accordingly.						
CRITERION 13C.1.1.2 (CORE)							
There is an organization chart which provides a clear representation of the structure~~,~~ designation and reporting relationships between the Person-In-Charge (PIC) and the staff of the centre.	1. Clearly delineated organization chart with structure, designation and line of reporting-between the Person-In-Charge (PIC) and staff of the centre is available and displayed in the centre.						
CRITERION 13C.1.1.3							
The Head of Services shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	1. Documented and approved BCP for unanticipated situations;						
	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment.						
	3. Clear actions and staff responsibilities during disruption;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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	4. Record of drills or tests, with follow-up actions, if conducted; and						
	5. Review of Risk Register.						

STANDARD 13C.1.2
The haemodialysis centre shall have a person responsible for all aspects of the centre's operations. The Person-in-charge can be the owner or appointed by the owner of the haemodialysis centre.

The Person-In-Charge (PIC) shall adopt a governing framework that abides by the current legislation that is suitable for the needs and circumstances of the centre.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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CRITERION 13C.1.2.1 (CORE)							
Governance of the haemodialysis centre The governance of a haemodialysis centre shall be the responsibility of the Person-In-Charge (PIC), who shall be: a) A Nephrologist/Paediatric Nephrologist with a National Specialist Register (NSR) certification or; b) A physician in Internal Medicine/Emergency/Family Medicine/Paediatrics with a National Specialist Register (NSR) certification in the respective fields who have completed the certified course of not less than 200 hours	1. Letter of appointment of PIC if the PIC is not the owner.						
	2. Valid Annual Practicing Certificate (APC) of the PIC.						
	3. Certificate of completion for 200 hours of recognized training in haemodialysis treatment. (If the PIC is not a nephrologist)						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
of training in haemodialysis treatment and maintains an affiliation with a nephrologist; and c) A registered medical practitioner other than those listed above who has completed the certified course of not less than 200 hours of training in haemodialysis treatment and maintains an affiliation with a nephrologist.	4. Letter of affiliation with nephrologist. (If the PIC is not a nephrologist)						
	5. Certificate of National Specialist Register (NSR). (only applicable for physicians and nephrologists)						
CRITERION 13C.1.2.2 (CORE)							
The Person-In-Charge shall adopt a governing framework in accordance with statutory and other legal requirements. The PIC is responsible for the management and control of the private healthcare facility or service to which a license or registration relates. The PIC is the person held legally responsible in the Act to manage, control, maintain and operate the haemodialysis centre. The roles and responsibilities of the PIC should be identified.	1. Valid license from Private Medical Practice Control Section (Cawangan Kawalan Amalan Perubatan Swasta, CKAPS);						
	2. The roles and responsibilities of the PIC include but not limited to the following:						
	a. Ensures monthly visits to the centre;						
	b. Ensures proper functioning and maintenance of the facility and equipment;						
	c. Ensures that the centre complies to with the norms and standards required;						
	d. Ensures that each patient has a nephrologist to assume all or part of the medical care of the patient;						
	e. Ensures there are standing arrangements with other medical practitioners to provide immediate medical						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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	care, essential life-saving measures and implement emergency procedures on any person requiring such treatment or services if the PIC is not available;						
	f. Ensures the safety of patients and staff of the centre;						
	g. Ensure periodic reviews ~~of~~ policies and procedures of the centre;						
	h. Ensures reviews and assesses performance of centre are carried out and implements improvements for quality care;						
	i. Ensures staff and patient education programmes are in place; and						
	j. If the PIC is not a nephrologist, the PIC should consult with the affiliated nephrologist on management of patients or any other matters pertaining to the centre when the need arises.						

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STANDARD 13C.1.3
ACCESS TO CARE
Patients with end-stage kidney disease shall have access to safe, efficient and effective treatment.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 13C.1.3.1 (CORE)							
Acceptance of patients into centre Patients with end-stage kidney disease requiring chronic haemodialysis treatment are accepted for treatment based on the facilities and human resource of the centre. The centre has a process for accepting patients, informing them of the services available and costs of treatment. It has guidelines in place to assist patients with any financial subsidies that they are entitled to.	1. The centre has written guidelines on assessment and acceptance of patients;						
	2. The numbers of patients accepted do not exceed the capabilities of the centre both in terms of the facilities and staffing aspects; and						
	3. Documented evidence of assisting relevant patients to obtain appropriate financial assistance. (This is not applicable for centres that do not provide financial assistance.)						
CRITERION 13C.1.3.2 (CORE)							
Access to regular dialysis treatments during change of schedule The PIC has the responsibility to ensure that patients received the dialysis treatment as per nephrologist's prescription should there be any interruptions.	1. Documented evidence that the centre has a mechanism to facilitate change for haemodialysis schedules. The ability to accommodate patients' request to change their dialysis schedule for valid reasons (e.g., attending family emergencies, attending other medical appointments depending on availability; and						
	2. Evidence that the centre has the mechanism to re-arrange haemodialysis schedules in case of						

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	services such as interrupted disruption of water/electric supply or maintenance work.						
CRITERION 13C.1.3.3 (CORE)							
Access to other medical care The centre is responsible for arranging access to a hospital or other facilities should the patients require additional medical treatment or services: a) The centre has arrangements with other healthcare providers, including ambulance services, to provide urgent care for patients; and b) Arrangements for other medical care including dietetic, vascular access services and others.	1. Documented evidence that patients have been attended by a registered medical practitioner timely in an emergency or the case is referred urgently for appropriate medical care; and						
	2. Access to ambulance services, e.g. at least contact numbers of two ambulance service providers.						

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TOPIC 13C.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD 13C.2.1
The Centre shall have adequate number of qualified and trained staff as well as other supporting staff commensurate with the workload.

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CRITERION 13C.2.1.1 (CORE)							
Affiliated Nephrologist- in-charge There shall be an appointed Nephrologist in charge whose responsibility is to ensure proper clinical management of the patients, delivery of safe and efficient treatment compliance with regulatory requirements and patient safety and welfare. a) There is a qualified Nephrologist-in-charge (NIC). The NIC is appointed by the PIC or owner of the centre. b) Roles and responsibilities of the NIC are identified.	1. The promotion of staff well-being may involve the following:						
	a. Valid Annual Practicing Certificate (APC) of the affiliated nephrologist;						
	b. Certificate of National Specialist Register (NSR); and						
	c. List of roles and responsibilities of the affiliated Nephrologist in Charge (NIC) include but not limited to the following:						
	i. Visit the centre at least once every 3 months and reviews each patient. The review shall be comprehensive and shall include, but not be limited to, clinical examination, review of blood and other test results, and medications;						
	ii. Advises on the facilities, equipment and staffing requirements of the centre;						
	iii. Ensures policies and standards for						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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	haemodialysis treatment in conformity with the requirements of the regulations and/or any nationally accepted guidelines;						
	iv. Plans clinical management and dialysis prescriptions for patients;						
	v. Recommends changes or modifications to treatment as deemed necessary from time to time in order to maintain the quality of care;						
	vi. Ensures the data submitted during annual return to NRR (National Renal Registry) is complete and accurate; and						
	vii. Reviews and updates the kidney transplant status of the dialysis patients regularly into MyKAS (MyKad Akuan Sumber).						
CRITERION 13C.2.1.2 (CORE)							
Haemodialysis Centre Manager/Staff in-charge There shall be a Haemodialysis Centre Manager/Staff in charge with post basic qualification in renal nursing whose	1. Letter of appointment of the Haemodialysis Centre Manager/Staff in- charge;						
	2. Evidence of post-basic qualification in renal nursing preferably with at least two (2)						

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responsibility is to ensure the proper management of the centre, compliance with regulatory requirements and patient safety and welfare. a) There is a qualified Haemodialysis Centre Manager/Staff in charge with post-basic qualification in renal nursing.It is preferable for the dialysis manager to have at least 2 years of working experience in a dialysis centre; and b) The roles and responsibilities of Haemodialysis Centre Manager/Staff in charge are identified.	years' experience in haemodialysis services;						
	3. Valid Annual Practising Certificate (APC);						
	4. List of roles and responsibilities of the Haemodialysis Centre Manager/Staff in charge include but not limited to the following:						
	a. Clinical oversight which includes compliance of facility with regulatory bodies;						
	b. Operational and facility management which include: i. Stock and inventory management; ii. Planning budgeting with NIC; and iii. Planned Preventive Maintenance (PPM) in a timely manner.						
	c. Quality assurance activities and compliance which include submission of incident reporting and registry data in a timely manner;						
	d. Coordination between PIC/NIC, staff, patients and family members;						
	e. Coordination and engagement of stakeholders; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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	f. Disaster preparedness.						
CRITERION 13C.2.1.3 (CORE)							
Registered Nurse/ Medical Assistant The centre should ensure that it has sufficient staff with formal training to meet patient care needs. a) Nursing staff assigned to a centre shall have at least six (6) months training in renal nursing and/or post-basic qualification in renal nursing. b) The centre should maintain personal information files for each employee documenting their qualifications, training, experience and continuing education activities. c) The roles and responsibilities of the registered nurse or medical assistant are identified.	1. Documented evidence of six (6) months training in renal nursing and/or post basic qualification in renal nursing;						
	2. Documented evidence of privileging for nursing staff who do not have post-basic qualification in renal nursing;						
	3. Valid Annual Practising Certificate (APC) for Staff Nurses and Medical Assistant;						
	4. Documentation of working hours of staff and roster;						
	5. Documented evidence of staff to patient ratio as per regulatory requirements;						
	6. Documented evidence of staff trained in cardiopulmonary resuscitation (CPR) in the centre. Roster should include at least one (1) CPR trained staff per shift;						
	7. List of roles and responsibilities of registered nurse/ Medical Assistant include but not limited to the following:						
	a. Performing haemodialysis treatment;						
	b. Monitoring of haemodialysis patients during treatment at regular intervals;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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	c. Performing and tracing regular blood tests and alerting the NIC/PIC of the abnormal results;						
	d. To recognize acute complications of Haemodialysis ,take remedial measures and inform doctor;						
	e. To adhere to infection control policies;						
	f. Administration of medication prescribed by the NIC/PIC;						
	g. Caring and maintaining the dialysis equipment and system; and						
	h. Providing health education to patients and their family members.						
	8. Personal files of staff are kept and made available. The files should include qualifications, training, experience and continuing medical education (CME) activities.						
CRITERION 13C.2.1.4							
Supporting staff The Centre may employ other non-clinical staff whose roles and responsibilities are clearly defined.	1. Letter of appointment of the supporting staff are available;						
	2. The roles and responsibilities of the supporting staff are listed;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Other support staff are appointed and clearly assigned to support the service needs.	3. Staff orientation and training records are available; and						
	4. Personal files of staff are kept and made available. The files should include qualifications and training, experience.						

STANDARD 13C.2.2
STAFF ORIENTATION (NEW)
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.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 13C.2.2.1 (NEW)							
There is a structured orientation programme for all newly appointed, contracted and outsourced staff to the Services that include but not limited to the following: **General** a) Vision and mission of the Facility; b) Organisation chart and reporting structure of the Facility; c) Environment and facility safety policies and procedures including sustainability practices; d) Infection control policies and procedures; e) Policies for performance management, patient safety	1. Policy requiring all new staff to attend a structured orientation programme;						
	2. There is Services orientation programme with relevant topics not limited to topics covered from (a) to (q); and						
	3. Attendance list.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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(IPSG/MPSG) and risk management; f) Ethical practices and code of conduct including medicolegal awareness; g) Management of aggression, violence and harassment; h) Patient and family rights **Services** i) Goals, objectives and organisational structure of haemodialysis centre; j) Policies and procedures relevant to haemodialysis centre; k) Working instructions for patient care; and l) Service continuity plan for haemodialysis centre in response to internal and external disasters. **Job-specific** m) Explanation of particular duties and functions; n) Explanation of the methods of assigning clinical care and the standards of clinical practice; o) Handover communication; p) Training in basic/advanced life support techniques; and q) Technology and equipment use including artificial intelligence, digital care and robotics.							

STANDARD 13C.2.3 (NEW)

The haemodialysis centre shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the haemodialysis centre staff, ensuring a safe and healthy work environment.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 13C.2.3.1 (CORE)							
The Services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being; a) A health-promoting environment, e.g., stress management, burnout staff, engagement opportunities, workload monitoring, management of work life balance, healthy, lifestyle programmes e.g. Workplace Wellness Programs, Community-Based Health Initiatives; b) Ambulatory Care Services staff shall be provided with appropriate supervision, support, and advice e.g., mentor mentee program; and c) There shall be clear procedures for the effective management of underperformance e.g., feedback on performance review or performance appraisal report.	1. The promotion of staff well-being may involve the following:						
		a. Evidence of a health promoting environment e.g., workplace wellness programme;					
		b. Evidence of proper supervision of staff; and					
		c. Evidence of staff appraisal programme with feedback on underperformance.					

DISTRIBUTION

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 13C.2.3.2 (CORE)							
The haemodialysis centre shall establish a safe mechanism for haemodialysis centre staff to express grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety.	1. Haemodialysis centre staff suggestions and grievance reporting and processing mechanisms are available;						
	2. The resolution of workplace issues may involve the following:						
	a. Measures and evidence of haemodialysis centre staff protection including whistleblowers against violence, bullying, and harassment e.g., awareness campaigns, anonymous reporting channel, Whistleblower policy; and						
	b. Documented policies and procedures for violence activation and haemodialysis centre staff protection.						
CRITERION 13C.2.3.3 (NEW)							
A system shall be created to gather staff feedback about their workplace experience such as burnout which shall be analysed and used to make improvements that enhance the work environment, staff satisfaction, and organisation culture.	1. Staff feedback (e.g., minutes of sessions or staff satisfactions survey);						
	a. Evidence of action or improvement taken.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 13C.2.3.4 (NEW)							
The haemodialysis centre shall track sick leave and haemodialysis centre staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning	1. Evidence that workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments. The results shall be used to create focused actions that improve staff well-being, solve problems, and help retain employees.						

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TOPIC 13C.3
POLICIES AND PROCEDURES

STANDARD 13C.3.1
CARE OF HAEMODIALYSIS PATIENT
All patients in the Centre shall receive haemodialysis treatment according to current national and/or international evidence-based guidelines.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 13C.3.1.1 (CORE)							
Clinical Care of Haemodialysis Patients All dialysis patients shall be regularly reviewed by a nephrologist at least three (3) monthly. The nephrologist review shall be comprehensive and includes assessment of dialysis related as well as non-dialysis related/other medical problems of the patients.	1. Policy on haemodialysis treatment;						
	2. Evidence of nephrologist's review in the dialysis patient's medical notes/records. This review shall include:						
	a. History and any complaints relating to the general health of the patient;						
	b. Physical examination including volume status and blood pressure control;						
	c. Dialysis clinical charts;						
	d. Results of the recent investigations;						
	e. Status of vascular access;						
	f. Intradialytic and long-term complications of treatment;						
	g. Medication prescribed to the patient;						
	h. Nutritional status and dietary advice;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	i. Kidney transplant status; and						
	j. Immunisation status and counselling for vaccination if required.						
CRITERION 13C.3.1.2 (CORE)							
Haemodialysis Prescription All patients shall have an individualized prescription for haemodialysis treatment which shall be reviewed at least three (3) monthly to ensure dialysis adequacy.	1. There is a prescription for haemodialysis treatment documented by a nephrologist;						
	2. Dialysis prescription for each patient shall be made available. This prescription shall include dialysis treatment parameters such as:						
	a. Dry weight;						
	b. Blood flow rate (Qb) and dialysate flow rate (Qd);						
	c. Type and dose of anticoagulation;						
	d. Dialysis duration and frequency;						
	e. Type and size of the dialysers;						
	f. Dialysate calcium and sodium;						
	g. Dialysate temperature;						
	h. Vascular access to be used;						
	i. Medication administered during dialysis;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 13C.3.1.3 (CORE)							
Haemodialysis Outcome All patients shall have haemodialysis outcome indices monitored at least three (3) monthly.	1. Policy on monitoring of haemodialysis treatment outcome;						
	2. Investigations done at least every three (3) months shall include but not limited to the following: (Refer Appendix 1):						
	a. Adequacy of dialysis including functioning vascular access;						
	b. Nutritional status;						
	c. Studies in anemia including iron studies;						
	d. Bone mineral metabolism;						
	e. Virology studies – to be done at least 6 monthly;						
	f. Sugar control if required;						
	g. Lipid control; and						
	h. Renal and liver function test;						
	3. All test results shall be monitored and documented; and						
	4. Documented evidence on action taken based on the results monitored.						

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STANDARD 13C.3.2
ETHICAL PRACTICE AND PATIENT & FAMILY RIGHTS
The Centre shall establish ethical guidelines that promote appropriate, safe and efficacious treatment. It shall have policies supporting patients' rights as well informing them of their responsibilities.

The Centre shall always ensure that at all times the best interests of patients shall prevail when there is a conflict between the business interests of the Centre and the patients' welfare.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 13C.3.2.1 (CORE)							
Confidentiality of Patient's Personal and Medical History Information on the patient's personal and medical history shall be always kept confidential. The Centre shall abide by the Malaysian Medical Council's guidelines on maintaining confidentiality of patient's records.	1. Written policy and procedures on the handling of medical records to protect the confidentiality of the patient's personal and medical information;						
	2. Evidence of patients' personal and medical information is kept in a secure manner and accessible only to designated staff.						
CRITERION 13C.3.2.2 (CORE)							
Informed Consent There shall be an informed consent before a patient is started on haemodialysis treatment. The informed consent document shall include the nature of treatment and short- and long-term potential complications of the therapy and the cost of care and access to other non-dialysis care.	1. There are policies and procedures guidelines that clearly define the process for informed consent;						
	2. Documented informed consent form specific for haemodialysis treatment is in place. Documented evidence that informed consent has been taken for each patient undergoing treatment at the centre. A standard consent form can be used; and						
	3. Informations on haemodialysis treatment and other related matters are available.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 13C.3.2.3 (CORE)							
Patient Rights and Responsibilities The centre shall have a guide on the rights and responsibilities of the patient undergoing dialysis to ensure his/her well-being and a best possible outcome. This shall be communicated to the patient when he/she starts treatment at the centre.	1. The charter of patients' rights is made available to all patients;						
	2. Responsibilities of patients are clearly communicated to them;						
	3. The centre shall provide services for a maximum of six (6) days per week, including on public holidays;						
	4. Patients' rights and responsibilities are displayed prominently in the Haemodialysis Centre:						
	a. There shall be adequate written information to for the patient on the nature of treatment, level of care expected and the fees charged;						
	b. Patients have a right to change haemodialysis centre, and PIC must facilitate the transfer. in the best interests of the patients;						
	c. There shall be an established a grievance mechanism and such mechanism shall be prominently displayed in the centre;						
	d. Documented evidence that patients have been informed and agreed to their responsibilities as a patient in the centre including communication that their demographic and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	clinical;data are submitted to the National Renal Registry in anonymised form. This can be in the form of a patient information sheet which is formally acknowledged by the patient;						
	e. Patients have a right to safe delivery of haemodialysis treatment. There shall be documented evidence that patients are monitored during dialysis and actions taken should there be an adverse event; and						
	f. In the event of closure of the haemodialysis centre, the patients have a right to be transferred to another centre and this is the responsibility of the PIC.						
CRITERION 13C.3.2.4 (CORE)							
The Person In Charge (PIC) of a Centre shall ensure adequate monitoring of patients during dialysis and subsequent patient care.	1. Evidence of patient's review every three (3) months by nephrologist; and						
	2. Evidence of patient's review as and when clinical needs arise.						
CRITERION 13C.3.2.5 (CORE)							
In the case of closure of the Centre, the PIC shall ensure there is continuity of care of all patients including transfer of patients to another Haemodialysis Centre.	1. Standard operating policy and procedure on continuity of care of all patients including transfer of patients to another Haemodialysis Centre.						

STANDARD 13C.3.3
PREVENTION AND CONTROL OF INFECTION

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 13C.3.3.1 (CORE)							
Prevention and Control of Blood-borne Viral Infections (A) Pre-admission Screening Screening of Blood-Borne Viral Infections (Hepatitis B, C & HIV) shall be carried out before patient is admitted for treatment at Haemodialysis Centre	1. There shall be guideline on pre-admission screening of blood-borne viral infections prior to admission; and						
	2. Evidence of pre-admission screening being performed for new admissions (including temporary transfer, own patients returning to centre) to the centre patient's medical records.						
CRITERION 13C.3.3.2 (CORE)							
Prevention and Control of Blood-borne Viral Infections (B) Monitoring of Blood-borne Viral Infections in the centre All patients in Haemodialysis Centre shall undergo regular scheduled monitoring for blood-borne viral infections.	1. There shall be a guideline on frequency of monitoring for blood-borne viral infections for all patients in the centre; and						
	2. Documented evidence of the results of the scheduled monitoring. (Refer to Appendix 1).						
CRITERION 13C.3.3.3 (CORE)							
Prevention and Control of Blood-borne Viral Infections (C) Managing patients with Blood-borne viral infections All patients in Haemodialysis Centre shall undergo regular	1. Guidelines on the management of patients with blood-borne viral infections; and						
	2. For patients those who are positive for Hepatitis B virus (HBV) and HIV infections, there is						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
scheduled monitoring for blood-borne viral infections.	evidence of a designated treatment room for dialysis;						
	3. For patients who are positive for Hepatitis C virus (HCV), there is evidence of a designated treatment room (preferable) or area for dialysis; and						
	4. All patients with blood-borne viral infections should be dialysed with single-use dialysers.						
CRITERION 13C.3.3.4 (CORE)							
Prevention and Control of Airborne/Droplet Infections There shall be procedures guidelines for handling patients with air-borne or respiratory droplets infections, e.g., COVID-19, MERS-CoV, Influenza, Tuberculosis	1. Guideline on management of infected patients;						
	2. Documented evidence of staff training on handling air-borne/droplet infections;						
	3. Documented evidence of patient education on cough etiquette;						
	4. Documented evidence and tracking of for vaccination of patients and staff immunisation; and						
	5. Audit on adherence to appropriate PPE as required.						
CRITERION 13C.3.3.5 (CORE)							
Screening for Visiting Patients and Centre's	1. Guidelines are in place to ensure screening of patients who dialyse temporarily at the centre;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
patients who have temporary dialysis elsewhere a) Patients from other centres who request to dialyse at the centre shall undergo screening for blood-borne viral infections; and b) The centre's own patients returning from dialysis treatment at other centres shall undergo similar screening.	2. Guidelines for screening of the centre's returning patients who temporarily dialyse outside the centre;						
	3. Documented evidence of results on screening tests of visiting patients; and						
	4. Documented evidence of tests being performed for the centre's patients who have returned to dialyse in the centre after treatment elsewhere.						
CRITERION 13C.3.3.6 (CORE)							
Designated Staff for Infection Control A designated staff and PIC who have been trained in prevention and control of infection shall oversee all prevention and control measures in the centre. The role & responsibilities include but not limited to: a) Conduct infection control surveillance b) Organize infection control training for staffs c) Organize patient education on infection control	1. Letter of appointment as designated staff for infection control;						
	2. Documented evidence that the designated staff has been trained in infection control;						
	3. Audit or minutes of meeting of designated staff and PIC to oversee the prevention and control infection measures in the centre; and						
	4. Documented evidence of submission of incident reporting in the event of a seroconversion in the centre.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
d) Conduct regular infection control meeting with PIC/Nephrologist e) Plan and execute quality improvement measures when required f) Submit incident reporting to MOH for HBV, HCV and HIV seroconversion and clusters of pyogenic infection.							
CRITERION 13C.3.3.7 (CORE)							
Documentation of Infections Documentation of infections are a necessary component for trending and tracking. Quality improvement programmes can be initiated based on the pattern of infections. There shall be complete documentation of infection complications within the centre, which include: a) Catheter Related Blood Stream Infections (CRBSI); b) Fistula Infection; and c) Pyogenic infections;	1. The centre shall have evidence of documentation and reporting mechanism when infections occur. Appropriate actions being taken following infections (i.e referral letter);						
	2. Documented clinical and laboratory evidence of such infections. (i.e. discharge summary if patient hospitalised);						
	3. There is evidence of actions being taken following a suspected infection. (i.e referral letter, discharge summary); and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
d) Blood-borne viral infections – Hepatitis B, C and HIV; e) Bacterial infections – MRSA, CRE, MRO; and f) Any communicable infections- i.e.Covid-19 infections.	4. The centre shall have a tracking and trending mechanism of infections.						
CRITERION 13C.3.3.8 (CORE)							
Management of Infected Patients There shall be guidelines on management of infected patients including drug treatment (where appropriate), isolation/segregation of treatment areas and use of designated equipment.	1. Written guidelines/policies on handling of infected patients and referral of patients to other centres. (Refer Appendix 2).						
CRITERION 13C.3.3.9 (CORE)							
Management of Clinical waste Clinical waste shall be managed in accordance with established policies and procedures to ensure safe handling, segregation, storage, and disposal. In Accordance with Guidelines on the Handling and Management of Clinical waste in Malaysia by Department of Environment, Ministry of Natural Resources	1. Dedicated storage area/unit for clinical waste must be available;						
	2. Secured and refrigerated storage areas/units for clinical wastes must be available where the temperature should be kept at 4°C to 4°C when clinical waste are not collected daily for disposal;						
	3. Documented evidence of clinical waste collection date and time must be available; and						
	4. Documented evidence of daily logging of room temperature where clinical waste is stored.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
and Environment 3rd Edition 2009, refrigerated storage areas/units should be considered when clinical wastes is not collected daily for disposal.							

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TOPIC 13C.4
FACILITIES AND EQUIPMENT

STANDARD 13C.4.1
The Centre complies with the requirements of the local authority, Private Healthcare Facilities and Services (PHFS) Act, Medical Devices Act, and any other relevant regulatory requirements.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 13C.4.1.1 (CORE)							
Structural Design of Haemodialysis Centre The centre shall have adequate space for the different functions of haemodialysis treatment as provided for under the Regulations of the Private Healthcare Facilities and Services Act for haemodialysis treatment. There is adequate space and storage areas to allow staff to carry out their duties safely and efficiently according to standards set by the relevant authorities and regulatory requirements	1. The approved floor plan should be available and displayed in the Centre.						
CRITERION 13C.4.1.2 (CORE)							
Equipment Standards Major equipment used in haemodialysis treatment shall have certification from relevant regulatory authorities.	1. There is documented evidence that major equipment used in haemodialysis treatment complies with relevant standards set by national and international bodies, e.g. SIRIM Berhad (Standards and Industrial Research Institute						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	of Malaysia), Medical Device Authority, etc.						
CRITERION 13C.4.1.3 (CORE)							
Water treatment system Water treatment systems are an important component in treatment. It must be well designed, maintained and monitored to prevent any complication that may arise from chemical and microbiological contamination. The centre shall adhere to the standards for maximum allowable chemical, bacterial and endotoxin contamination based on minimum requirements of ISO 23500:2024 Standards. The centre shall have guidelines on monitoring water quality. Refer Appendix 1 and 2 (The National Haemodialysis Quality Standards 2018)	1. The schematic diagram of water treatment system shall be available and displayed in the centre;						
	2. Documented evidence of chemical disinfection performed;						
	3. There is documented evidence of:						
	a. Daily logging;						
	b. Chlorine testing;						
	c. Water hardness testing;						
	d. Monthly endotoxin testing; and						
	e. 6-monthly chemical testing.						
	4. Documented evidence that action is taken when required (abnormal test results).						
CRITERION 13C.4.1.4 (CORE)							
Resuscitation equipment and medication	1. A list of items (within expiry) shall be made available in the resuscitation trolley shall be made available; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
The centre shall have a complete set of resuscitation equipment and medication.	2. Documented evidence that the items in the resuscitation cart are checked at regular intervals.						
CRITERION 13C.4.1.5 (CORE)							
Maintenance of Equipment The equipment in the centre shall be maintained in good working order and subjected to regular planned preventive maintenance (PPM) and calibration.	1. Guidelines on equipment maintenance;						
	2. Contract for equipment maintenance; and						
	3. There should be a logbook on the maintenance and repairs of all major equipment.						
CRITERION 13C.4.1.6 (CORE)							
Storage of cold-chain medication The centre shall have a pharmaceutical refrigerator to store cold-chain medication	1. Documented evidence on temperature logging						
	2. Documented evidence of action taken should there be a temperature excursion						
CRITERION 13C.4.1.7 (CORE) (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care	1. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care.						

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TOPIC 13C.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 13C.5.1
The centre has a framework of quality objectives and the processes to achieve these objectives.

The PIC of centre shall ensure staff involvement in the continuous safety and performance improvement activities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 13C.5.1.1 (CORE)							
Performance Improvement Activities The centre shall have a framework of performance improvement programme/s that need to be carried out in the centre from time to time. The PIC shall ensure that all staff are involved in these activities to improve outcomes. a) The PIC shall ensure that there is a clear plan to improve the quality of care in the Centre; b) The PIC assigns the responsibility for performance improvement activities to a designated staff; c) The PIC shall ensure that the staff are trained in performance improvement activities and undergo continuous education;	1. Documented evidence of plan for performance improvement activities which shall be reviewed and updated regularly;						
	2. Maintaining records of staff attending continuing education activities on performance improvement;						
	3. Letter of assignment of responsibilities for performance improvement activities;						
	4. Documentation of quality improvement parameters shall include:						
	a. **Mandatory** incident reporting: i. Viral hepatitis and HIV seroconversion; and ii. Intradialytic death in chronic stable dialysis patient.						
	b. Clinical outcome measures (Refer Appendix 4): i. Documented evidence of certificate of compliance from NRR						
	c. Risk Assessment Audit – i.e. patient fall. Catheter						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
d) The PIC shall ensure that there is appropriate documentation on safety and performance improvement activities; e) The PCI shall monitor performance improvement activities using available data collection formats; and f) The PIC shall ensure that these data are kept in a safe manner.	dislodgement, venous needle dislodgement;						
	d. Infection Control Audit – i.e.pyogenic reactions, CRBSI;						
	e. Medication errors; and						
	f. Needle-prick injuries.						
CRITERION 13C.5.1.2 (CORE)							
Disaster preparedness The centre shall have policy and procedure on disaster preparedness.	1. Documented evidence on work-flow during disaster;						
	2. Documented evidence of plan for patient transfer in the event of disaster;						
	3. Documented evidence of staff training on disaster preparedness;						
	4. Documented evidence on patient education on disaster preparedness; and						
	5. Documented evidence that patient's data is regularly updated including contact numbers, latest blood parameter and medication lists.						
CRITERION 13C.5.1.3 (NEW)							
The Services participates in the Facility's safety culture	1. Safety Culture Survey for staff						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
assessment. The results are utilized by Service leadership to inform and guide efforts to improve the culture of safety within the Service.							

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SERVICE SUMMARY	
OVERALL RATING :	
OVERALL RISK :	

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MINIMUM SCHEDULED LABORATORY INVESTIGATIONS FOR CHRONIC PATIENTS

TESTS	MINIMUM FREQUENCY
Full blood count	3 monthly
Iron Study: Serum Iron Serum ferritin Total Iron Binding Capacity (TIBC) Transferrin saturation (TSAT) % Hypochromic red cells or reticulocyte Hb content (if available)	3 monthly More frequent monitoring is required when: • Initiating or increasing ESA therapy • Monitoring response to IV iron or • Iron deficiency is suspected.
Blood urea (pre and post dialysis)	3 monthly
Renal Function Test	3 monthly
Liver Function Test Alanine Transaminases (ALT) Alkaline Phosphatase (ALP) Serum albumin	3 monthly *Consider more frequent ALT tests as indicated.*
Calcium and phosphate	3 monthly
Fasting iPTH	3-6 monthly
Fasting Serum Lipid	6 monthly
Blood sugar	3 monthly (diabetics) 6 monthly (non-diabetics)
HbA1C (if diabetics)	3-6 monthly

ALP=alkaline phosphatase, ALT=alanine transaminase, HbA1C=glycosylated hemoglobin, PTH=intact parathyroid hormone, TSAT=transferrin saturation.

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APPENDIX 2

WATER QUALITY

a) Water Production Process
Dialysis water shall be produced by the process of Reverse Osmosis

b) Quality Standards
Water quality shall comply with the minimum standards of ISO23500:2024

c) Chemical Contaminants
Permissible levels of chemical contaminants shall be observed and adhered to. Refer to Appendix 5

i) Method of Testing
1) Total chlorine and water hardness testing shall be performed onsite using commercially available test kits; and
2) Full analysis of chemical contaminants shall be performed by an accredited laboratory.

ii) Frequency of Testing
1) Total chlorine and water hardness should be tested at least daily; and
2) Chemical analysis of water should be tested at least 6-monthly in an accredited laboratory

iii) Site of testing
1) Testing for total chlorine shall be performed after the first carbon column;
2) Testing for hardness after softener column; and
3) Water for chemical analysis shall be collected at raw water point, pre and post RO.

iv) Action if limits exceeded
1) Evaluate water treatment system and rectify as necessary

v) Record
1) All the results shall be properly documented and made available for inspection

d) Microbial Contaminant
i) Method of Testing
1) Total viable count (colony forming units) shall use heterotrophic plate count using various available and standard culture media; and
2) The presence of pyrogen/endotoxin shall be determined using Limulus Amoebocyte Lysate (LAL) method.

ii) Frequency of Testing
1) Weekly for newly installed water treatment system as part of validation;
2) Monthly for bacterial count and endotoxin test; and
3) For centre using HDF treatment, dialysate endotoxin and microbial colony forming unit shall be performed monthly.

iii) Sites of Sampling
1) Minimum sites of sampling for testing:
A. Post RO membrane;
B. First point of the distribution loop;

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C. End point of distribution loop (Last machine port) ;
D. Reprocessing bay (for indirect feed); and
E. Dialysis fluid sampling port where available (for HDF treatment).

iv) Handling of Water Sample
1) Assay within 30 minutes of collection
2) If immediate assay is not possible, refrigerate immediately at 5^{o}C and assay within 24 hours of collection

v) Limits and Action Level

CURRENT RECOMMENDED MICROBIAL PURITY IN WATER QUALITY

Solution	ISO 23500:2019			
	Viable count (CFU/ml)		Endotoxin (EU/ml)	
	Limit	Action	Limit	Action
Dialysis water	< 100	50	< 0.25	0.125
Dialysis fluid	< 100	50	< 0.5	0.25
Ultra-pure dialysis fluid	< 0.1	-	< 0.03	-
Substitution fluid	< 10^{-6}	-	< 0.03	-

If action levels are observed, disinfection and retesting shall be done immediately to restore the quality to acceptable level

vi) Laboratory
1) All samples shall be sent to an accredited laboratory

vii) Record
1) All the results shall be properly documented and made available for inspection

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APPENDIX 3

MAXIMUM ALLOWABLE LEVELS OF TOXIC CHEMICAL AND DIALYSIS FLUID ELECTROLYTES IN DIALYSIS WATER (BASED ON ISO 23500:2019)

Contaminants with documented toxicity in	
Contaminant	**Maximum Concentration (mg/l)**
Aluminium	0.01
Total Chlorine	0.1
Copper	0.1
Fluoride	0.2
Lead	0.005
Nitrate (as N)	2
Sulphate	100
Zinc	0.1

Electrolytes normally included in dialysis fluid		
Electrolytes	**mg/dl**	**mmol/L**
Calcium	2	0.05
Magnesium	4	0.15
Potassium	8	0.2
Sodium	70	0.3

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Maximum allowable levels of trace elements in dialysis water	
Contaminant	**Maximum Concentration (mg/l)**
Antimony	0.006
Arsenic	0.005
Barium	0.1
Beryllium	0.0004
Cadmium	0.001
Chromium	0.014
Mercury	0.0002
Selenium	0.09
Silver	0.005
Thallium	0.002

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APPENDIX 4

PATIENT-CENTRED QUALITY MEASURE BASED ON CLINICAL OUTCOME MEASURES

Outcomes	Measures	Notes
Mortality	**Mortality rate**	**Monthly Mortality Rate (%)** = No of deaths in the current month / No of patients at end of previous month x 100% **Annual mortality rate (%)** = Total no of death in the year / Average number of Patients per month X100% ● **Exclude those who stopped dialysis or received transplant**
Hospitalisation	**Unplanned Hospitalisation rate**	**Unplanned Hospitalization Rate (%)** = Unplanned admission (e.g by cause) / Average dialysis patients x 100 ● **Exclude planned admissions i.e., transplant admission, AVF creation,** ● **Consider categorizing by cause to target quality improvement**
Infection	**CRBSI** **(Catheter Related Blood Stream Infection)**	**CRBSI Rate (per 1000 catheter days)** **=** Number of Confirmed CRBSI Episodes / Total Catheter-Days × 1000 ● **Target: CRBSI rate < 1 in 1000-catheter day** ● **CRBSI Episode: Clinically confirmed CRBSI** ● **Catheter-Days: Total number of days all patients had catheters in place during the observation period.**
	Access Management	● **% of prevalent patient (on dialysis more than 1 year) using native AVF** ● **Suggested standard > 70%**

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Dialysis outcome	**Small molecule clearance**	• **95% of patients have prescribed Kt/V > 1.3** • **90% of patients have delivered Kt/V > 1.2 or URR > 65%**
	Anaemia	• **70% of patients achieved Hb ≥ 10 – 12 g/dL in patient on ESA** • **90% of patients achieved serum ferritin > 100 ng/ml** • **80% of patients achieved TSAT > 20%**
	Nutrition	• **75% of patients serum albumin ≥ 35g/l**
	CKD-MBD	• **50% of patients achieved serum PO_4^3< 1.8mmol/l**

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SERVICE STANDARD 14: RADIOLOGY SERVICES

PREAMBLE

Radiology is a branch of medicine that uses imaging technology to screen, diagnose, and management of diseases. Radiology services comprise of, diagnostic and interventional radiology. Medical practitioners who specialise in radiology are called radiologists. Diagnostic radiology examinations include:

a) General Radiography;
b) Dental Radiography;
c) Fluoroscopy;
d) Ultrasonography;
e) Computed Tomography (CT) Fluoroscopy/Angiography, Magnetic Resonance Imaging (MRI);
f) Mammography;
g) Bone Mineral Densitometry (BMD); and
h) Positron Emission Tomography – Computed Tomography (PET-CT) reporting.

Interventional Radiology

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.
Some of the examples of interventional radiology procedures include:

a) Needle biopsies e.g liver, lung, bone, thyroid gland etc.;
b) Venous sampling e.g adrenal and petrosal sinus;
c) Drainage procedures e.g Nephrostomy/PTBD;
d) 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;
e) /AVM/Aneurysm;
f) Unblock the blockage vessels e.g. Stroke thrombectomy/Vasculopathy/stenting;
g) Ablation therapy; and
h) Cancer treatments e.g TACE/SIRT.

Forensic Radiology

Forensic Radiology is a specialized area by using any imaging modality involving clinical forensic cases (under Police 59/ PDRM (S)59) and forensic pathology cases (under Police 61/PDRM (S) 61) as an adjunct examination to assist medicolegal forensic cases which may be tendered as evidence to the court.
Some examples of forensic radiology examination with procedures include:

a) General Radiography;
b) Dental Radiography;
c) Ultrasonography – clinical forensic cases;

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d) Post Mortem Computed Tomography (PMCT) – eg PMCT Angiography (PMCTA), PMCT biopsy, clinical post mortem CT; and
e) Post Mortem Magnetic Resonance Imaging (PMMRI) – selective in the specialized areas such as paediatric, adult cerebral system, adult cerebral vascular and adult cardiovascular cases.

Environmentally sustainable radiological services include optimizing imaging protocols, utilizing cloud-based picture archiving and communication systems (PACS), and adopting energy-saving measures integrating environmental, economic and social dimensions into medical imaging.

TOPIC 14.1
ORGANISATION AND MANAGEMENT

STANDARD 14.1.1
The Radiology Services provide safe, efficient and environmentally sustainable radiological services. The services shall be coordinated with other departments and services of the Facility.
A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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 are measurable 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); and						
	4. Achievement of goals and objectives are monitored, reviewed and revised accordingly.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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) is revised when there is a major change in any of the following: i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns.	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; and						
	3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).						
CRITERION 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.	1. Minutes are accessible, disseminated and acknowledged by the staff;						
	2. Attendance list of members with adequate representation of the service;						
	3. Frequency of meetings as scheduled; and						
	4. Discussion and resolutions are implemented.						
CRITERION 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; and	1. Attendance in department/Facility-wide mortality and morbidity meetings or conferences;						
	2. Participation in interdepartmental clinical radiological discussion/conference and multidisciplinary meetings; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.	3. Department/Facility-wide Continuing Medical Education (CME) programme; and						
	4. Attendance in conferences and courses organised by professional bodies.						
CRITERION 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, including implementing environmentally sustainable radiology practices. 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: a) In the case of government facilities, the services shall be overseen and supervised by the state radiologist or the assignee. b) 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.	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; and						
	4. Documented evidence related to environmentally sustainable radiology practices (e.g procurement of green certified equipment and/material)						

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CRITERION 14.1.1.6							
The Head of Radiology Services is involved in the appointment and/or assignment of staff.	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; and						
	5. Duty roster						
CRITERION 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.	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; and						
	e. Staff training records;						
CRITERION 14.1.1.8 (NEW)							
The Head of Services shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	1. Documented and approved BCP for unanticipated situations;						
	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and						

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	d. Risk treatment.						
	3. Clear actions and staff responsibilities during disruption;						
	4. Record of drills or tests, with follow-up actions, if conducted; and						
	5. Review of Risk Register.						

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TOPIC 14.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD 14.2.1
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.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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; and						
	7. Practising radiologist registered with National Specialist Register (NSR).						
CRITERION 14.2.1.2							
The authority, responsibilities and accountabilities of the Head of	1. Appointment/assignment letter for Head of Service; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Radiology Services are clearly delineated and documented.	2. Description of duties and responsibilities						
CRITERION 14.2.1.3							
Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the need of the services.	1. Number of staff and qualification should commensurate with workload;						
	2. Staffing pattern; category and distribution;						
	3. Duty roster; and						
	4. Census and statistics.						
CRITERION 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;	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; and						
	4. The job description is acknowledged by the staff and signed by the Head of Service and dated.						

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iii) General and specific accountabilities; iv) Qualifications required and privileges granted; v) Staffing patterns; and vi) Statutory Regulations. e) Administrative and clinical functions.							
CRITERION 14.2.1.5							
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.	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; and						
	g. Confidentiality agreement.						
CRITERION 14.2.1.6							
	1. Qualified radiographers to carry out radiographic procedures;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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All radiographic procedures shall be carried out by appropriately qualified, competent and privileged personnel	2. Credentialing and privileging processes are in place; and						
	3. Documented evidence on conferment of privileging rights (with valid period).						
CRITERION 14.2.1.7							
A radiologist and radiographer shall be on duty or be available on call after normal working hours.	1. Duty roster of the department/service; and						
	2. On-call roster						
CRITERION 14.2.1.8							
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.	1. Training needs assessment is carried out and gaps identified;						
	2. Staff development plan based on training needs assessment is available;						
	3. Training schedule/calendar is in place; and						
	4. Training module.						
CRITERION 14.2.1.9							
There are continuing education activities for staff including medical practitioners to pursue professional interests and to prepare for current and future changes in practice.	1. Contents of training programme;						
	2. Training records on continuing education activities are kept and maintained for each staff.; and						
	3. Certificate of attendance/diploma/degree						
CRITERION 14.2.1.10							
Staff including medical practitioners receive evaluation of their	1. Performance appraisals for staff including medical practitioners are						

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performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.	completed upon probationary period and as an annual exercise.						
CRITERION 14.2.1.11							
In a teaching hospital and recognised training facility, the Radiology Services shall provide educational needs and teaching for undergraduates and postgraduates without compromising patient safety and comfort.	1. Records on training provided to undergraduate and postgraduate students						
CRITERION 14.2.1.12							
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.	1. Records on participation or cooperation in teaching and research programme						

STANDARD 14.2.2
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.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 14.2.2.1 (NEW)							
There is a structured orientation programme for all newly appointed, contracted and	1. Policy requiring all new staff to attend a structured orientation programme;						

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outsourced staff to the radiology services including medical practitioners and for those new to specific areas that include but not limited to the following: **General** a) Vision and mission of the Facility; b) Organisation chart and reporting structure of the Facility; c) Environment and facility safety policies and procedures including sustainability practices; d) Infection control policies and procedures; e) Policies for performance management, patient safety (IPSG/MPSG) and risk management; f) Ethical practices and code of conduct including medicolegal awareness; g) Management of aggression, violence and harassment; h) Patient and family rights; i) Policy on radiation safety, contrast safety and MRI safety; j) Knowledge on Radiation protections and MRI safety aspects; and k) Importance of radiation dose monitoring and mandatory use of radiation monitoring badges.	2. There is a radiology services orientation programme with relevant topics not limited to topics covered from (a) to (t); and						
	3. Attendance list						

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Services a) Goals, objectives and organisational structure of radiology services; b) Policies and procedures relevant to radiology services; c) Working instructions for patient care; and d) Service continuity plan for radiology services in response to internal and external disasters **Job-specific** e) Explanation of particular duties and functions; f) Explanation of the methods of assigning clinical care and the standards of clinical practice; g) Handover communication; h) Training in basic/advanced life support techniques; and i) Technology and equipment use including artificial intelligence, digital care and robotics.							

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STANDARD 14.2.3

The Radiology Services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the radiology services staff, ensuring a safe and healthy work environment.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 14.2.3.1 (CORE)							
The radiology services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being. a) A health-promoting environment, e.g., stress management, burnout, staff engagement opportunities, workload monitoring, management of work life balance, healthy, lifestyle programmes e.g. Workplace Wellness Programs, Community-Based Health Initiatives; b) Staff shall be provided with appropriate supervision, support, and advice e.g., mentor mentee program; and c) There shall be clear procedures for the effective management of underperformance e.g., feedback on performance review or performance appraisal report.	1. The promotion of staff well-being may involve the following:						
	a. Evidence of a health promoting environment e.g., workplace wellness programme;						
	b. Evidence of proper supervision of staff; and						
	c. Evidence of staff appraisal programme with feedback on underperformance.						
CRITERION 14.2.3.2							
The radiology services shall establish a safe mechanism for radiology services staff to express grievances, provide	2. Radiology staff suggestions and grievance reporting and processing mechanisms are available;						

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suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety.	3. The resolution of workplace issues may involve the following:						
	a. Measures and evidence of radiology staff protection including whistleblowers against violence, bullying, and harassment e.g., awareness campaigns, anonymous reporting channel, Whistleblower policy; and						
	b. Documented policies and procedures for violence activation and radiology staff protection.						
CRITERION 14.2.3.3 (NEW)							
A system shall be created to gather radiology staff feedback about their workplace experience, such as burnout which shall be analysed and used to make improvements that enhance the work environment, staff satisfaction, and organisation culture.	1. Staff feedback (e.g., minutes of sessions or staff satisfactions survey)						
	a. Evidence of action or improvement taken.						
CRITERION 14.2.3.4 (NEW)							
The radiology services shall track sick leave and radiology staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning	1. Evidence that workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments. The results shall be used to create focused actions that improve radiology staff well-being, solve problems, and help retain radiology employees.						

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.

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CRITERION 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, current standard practices and Patients and Family Rights. 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.	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; and						
	4. The policies and procedures are endorsed and dated.						
CRITERION 14.3.1.2							
The policies and procedures shall be developed by the Radiology Services staff in consultation with representatives from other related services.	1. Policies and procedures show evidence of cross references to relevant sources that are involved in the processes; and						

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	2. Minutes of meeting between relevant departments.						
CRITERION 14.3.1.3							
Current policies and procedures are communicated to all staff.	1. Training and briefing on the current policies and procedures/ with minutes of meetings; and						
	2. Circulation list and acknowledgement						
CRITERION 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 i) Radiation Safety; ii) MR Safety; iii) Drugs and Contrast Media safety; management of complications; iv) Infection control; v) Fire Safety; vi) Occupational Safety; and vii) Safety in Digital Care and Artificial Intelligence (AI).	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; and						
	3. Investigative procedures performed are documented.						

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f) Communication with referrer, nursing, and other relevant staff on matters related to the services provided; g) Informed consent and Patient Information Sheet; 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; m) Patients and family rights; and n) Contingency plan.							
CRITERION 14.3.1.5 (CORE)							
There is Evidence of Compliance with policies and procedures.	1. Compliance with policies and procedures through:						

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	a. Interview of staff on practices;						
	b. Verify with observation on practices;						
	c. Results of audit on practices; and						
	d. Verify practices in line with established policies and procedures.						
CRITERION 14.3.1.6							
Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws, and statutory requirements are accessible to staff.	1. Copies of related documents are accessible for staff reference.						
CRITERION 14.3.1.7							
Radiological 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.	1. Policy on request for radiological investigation or procedure; and						
	2. Clinical indication/information is available on the request form/clinical order entry prior to the examination.						
CRITERION 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	1. Reports of radiological examinations are made by a radiologist/medical practitioner under the supervision of a radiologist; and						

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a competent, privileged medical practitioner.	2. All radiological reports shall be signed and stamped by radiologist and/or medical practitioner based on the local policy.						
CRITERION 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.	1. Special radiological reports are available within 2 days;						
	2. Reports of special radiological procedures are made by a radiologist; and						
	3. Copy of radiological report is kept in the patient's medical record.						
CRITERION 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.	1. Documented evidence that the clinician has been informed on the critical or unexpected findings.						
CRITERION 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	1. Policy on handing of hard or soft copy images by staff or patients;						
	2. Documented evidence on hard or soft copy images tracking system; and						

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be stored vertically in an air-conditioned room with suitable environmental conditions to prevent fungus, and in a manner for easy retrieval.	3. Proper storage of hard or soft copy images.						
CRITERION 14.3.1.12							
Where the policy of the Facility allows patients to take their hard or soft copy images home, they shall be advised to take proper care of the images and make them available whenever necessary. In Facilities where the images are not returned to patients, the images may be given or loaned for the purpose of obtaining a second opinion.	1. Policy for allowing patient to take their hard or soft copy images home and the documented evidence of implementation; and						
	2. Policy on request for loan of hard or soft copy images for purpose of second opinion.						
CRITERION 14.3.1.13 (CORE)							
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); c) Regulations 1986; d) Atomic Energy Licensing Act 1984 [Act 304]: Atomic	1. Standard operating procedures for radiological safety precautions are available and implemented; and						
	2. Verification on practice during survey.						

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Energy Licensing (Basic Safety Radiation Protection) Regulations 2010; e) Akta Perlesenan Tenaga Atom [Akta A1779] Pindaan 2025; and f) Refer to National Radiology Services Operational Policy MOH 2019).							
CRITERION 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.	1. Documented policy on radiation protection. This is a mandate to protect patients from unnecessary radiation exposure; and						
	2. Observe the practice during survey						
CRITERION 14.3.1.15							
There are written procedures for: management of a) Adverse drug or contrast media reaction anaphylactic reaction; and b) Complication of diagnostic and therapeutic interventional procedures. There is easy access to emergency and resuscitation equipment and medical alerts.	1. Documented procedures for management of adverse drug or contrast media reaction, anaphylactic reaction, or any complications during radiological procedures; and						
	2. Evidence of access to/availability of emergency and resuscitation equipment and medical supplies.						
CRITERION 14.3.1.16							
Guidelines for patient preparation and procedures for radiological examinations shall be available to all relevant staff.	1. The documented standard operational procedures and protocols for all radiological examinations must be available						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 14.3.1.17							
A technical manual for equipment shall be available within the Radiology Services	1. Technical manual for equipment is available.						
CRITERION 14.3.1.18							
There is a policy to ensure safety and confidentiality of all images.	1. Verify on user access and control on all images.						
CRITERION 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; and 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.	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.						
CRITERION 14.3.1.20							
Staff involved in the operating of ionising equipment shall	1. Evidence of medical examination by medical practitioner including full						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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); and c) Termination/completion of services.	blood count and chest x-ray as per items (a) to (c).						
CRITERION 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.	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;						
	4. Radiation doses for pregnant workers should be strictly monitored separately during the entire length of pregnancies and segregated for record keeping; and						
	5. Presence of documented evidence that all pregnant workers must						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	declare and notify their pregnancies to the Head of Service/Radiation Safety officer.						

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TOPIC 14.4
FACILITIES AND EQUIPMENT

STANDARD 14.4.1
The Radiology Services shall be provided with sufficient space, suitable equipment and adequate supplies for the safe performance of all radiological services provided.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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; and						
	5. Absence of overcrowding.						
CRITERION 14.4.1.2							
There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.	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; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	2. Testing, commissioning and calibration records (certificates or stickers)						
CRITERION 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.	1. Planned Preventive Maintenance records such as schedule, stickers, etc.;						
	2. Planned Replacement Programme where applicable;						
	3. Complaint records; and						
	4. Asset inventory						
CRITERION 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.	1. Certificate from Class H license holders						
	2. Records on Quality Control report						
CRITERION 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 equipments, e.g. Computed Tomography (CT), Magnetic Resonance Imaging (MRI), Mammography, etc and relevant AI-related software.	1. User training records;						
	2. Competency assessment record;						
	3. Evidence of privileging; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	4. List of staff trained and privileged to operate and maintain specialised equipment.						
CRITERION 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	1. Verification on practices for staff and patient;						
	2. Documented evidence of personal radiation protective device testing and record; and						
	3. Policy and documented evidence of investigation and report for accidental exposure to radiation for pregnant patients.						
CRITERION 14.4.1.7							
Multilingual signs warning women of childbearing age with regards to radiation exposure and pregnancy shall be prominently displayed on every door / wall outside of the imaging rooms.	1. Availability of multilingual signs warning women of childbearing age as well as clear trefoil Radiation symbol be placed prominently at all entrance/door to imaging rooms; and						
	2. Mandatory documentation of Last Normal Menstrual Period for all women of child bearing age.						
CRITERION 14.4.1.8							
There shall be suitable changing rooms for patients and facilities to keep their personal valuables.	1. Changing room and facilities to keep patient's valuables.						
CRITERION 14.4.1.9							

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
There is adequate space or area for patient preparation and observation pre and post radiological procedure.	1. Adequate space for patient preparation and observation pre and post radiological procedures; and						
	2. Verification on practices during survey						
CRITERION 14.4.1.10							
There is designated area for patient and accompanying person for; a) Special handling/need patient e.g. Irradiated patient, psychiatric patient and person under custody; b) Consultation, grievances and physical privacy; and c) Elderly patients, Patient on wheelchairs, trolleys or paediatric patients on strollers.	1. Ensure available space for (a) to (c)						
CRITERION 14.4.1.11 (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care.						

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TOPIC 14.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 14.5.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 14.5.1.1							
There are periodical 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-valuation for improvement; and g) Innovation.	1. Planned performance improvement activities include (a) to (g);						
	2. Records on performance improvement activities;						
	3. Minutes of performance improvement meetings;						
	4. Performance improvement studies; and						
	5. Records on innovation if available.						
CRITERION 14.5.1.2							
The Head of Radiology Services has assigned in a written document responsibilities to appropriate individuals/team/committees for safety, performance improvement and risk management activities within the services	1. Minutes of meetings;						
	2. Letter of assignment of responsibilities; and						
	3. Terms of Reference/Job description.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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	1. System for incident reporting is in place, which include:						
	a. Training of staff;						
	b. Policy on incident reporting;						
	c. Methodology of incident reporting; and						
	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; and						
	8. Feedback given to staff regarding incident reporting.						
CRITERION 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.	1. Plans for patient safety, quality improvement and risk management.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Minutes of meetings;						
	2. Terms of reference of the Clinical Risk Management Team; and						
	3. Reports.						
CRITERION 14.5.1.6							
The Clinical Risk Management Team shall: a) Review all clinical risk assessments, incident reports, audits, safety and performance improvement activities; and 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.	1. Documentation of reviews of risks such as radiation hazards, Mortality and Morbidity reviews, etc; and						
	2. Reports on clinical risk assessment.						
CRITERION 14.5.1.7							
There is identification and stratification of risks and measures to protect the safety of patients, staff and visitors in	1. Risk register on type of risks identified;						
	2. Stratification of risks; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and i) Training, competency and experience	3. Measures undertaken to address identified risks to protect the safety of patients, staff and visitors.						
CRITERION 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) For Facility with Radiologist i) Percentage of reject/ retake of plain radiographs (Target < 5%); ii) Percentage of reject / retake of mammogram images (Target < 3%); iii) Percentage of radiological examination and radiographic errors, i.e., wrong marker, use of primary markers, wrong site x-rayed, wrong patient x-rayed.	1. Specific performance indicators monitored;						
	2. Records on tracking and trending analysis;						
	3. Remedial measures taken where appropriate						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
iv) complication rate for post-interventional procedures; v) Perfect, Good, Moderate, Inadequeste (PGMI) audits for mammography (Target: ≥97% for Perfect, Good and Moderate); vi) Percentage of patients with significant pneumothorax/haemorrhage requiring intervention following percutaneous interventional procedures in the thorax, abdomen and pelvis. (Target: ≤10%); vii) Percentage of patients with waiting time of ≤60 minutes for commencement of ultrasound examination. (Target: >90%); viii) Turnaround time of ≤2days for final report of special radiological examination done on inpatients. (Target:≥97%); ix) Turnaround time of ≤14days for final report of special radiological examination done on							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
outpatients. (Target : ≥90%); and x) 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) Percentage of reject / retake of plain radiograph; (target <5%); and iii) Percentage of radiographic errors, i.e. wrong marker, use of primary markers, wrong site x-rayed, wrong patient x-rayed.							
CRITERION 14.5.1.9 (NEW)							
The Services participates in the Facility's safety culture assessment. The results are utilized by Service leadership to inform and guide efforts to improve the culture of safety within the Service.	1. Safety Culture Survey for staff						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 14.5.1.10							
Feedback on the results of safety and performance improvement activities is regularly communicated to the staff to promote transparency, shared learning, and active engagement in improvement initiatives.	1. Results on safety and performance improvement activities are accessible to staff through education sessions, meetings and digital communications.						
CRITERION 14.5.1.11							
Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved	1. Documentation on performance improvement activities and performance indicators; and						
	2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						

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TOPIC 14.6
SPECIAL REQUIREMENTS

STANDARD 14.6.1
VIEWING SYSTEM FOR REPORTING
The Facility shall use appropriate viewing boxes and display monitor to conduct the reporting of radiological images in satisfactory conditions.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 14.6.1.1							
Viewing boxes requirements for reporting radiographs by radiologists are as follows: a) Radiographic Viewing (non-mammographic) i) Radiographic illuminators: 1) Luminance preferably between 1500-3000 cd/m2; 2) Uniformity of illuminator (maximum deviation < 15%); 3) Uniformity of colour bulbs within the department (white or moderate white–blue with flicker-free illumination); 4) Sufficient size for at least 2 radiographs (>40 x 80 cm); 5) Possibility of collimation on the size of the radiographs; and	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;						
	5. Policy on and documented proof of approval for off site reporting by Radiologists;						
	6. Monitoring of reporting performed remotely or offsite to ensure display monitors and all hardware & tools used comply with the minimal standards of diagnostic quality /medical grade; and						
	7. Report of periodic audit trail of system used to assess the hospital network remotely to ensure data safety and prevent leak of patients confidential data.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
6) Viewing box mounting shall be at an appropriate level for reviewing. ii) Special viewing possibilities: 1) 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: 1) Magnifying factor 2-3. iv) Illumination conditions in the room: 1) 50 – 100 lux at the place of the viewer (with the viewer 'off'); and 2) 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							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
with variable illumination capability; ii) Room ambient illumination level: 50 lux or less (with viewer 'off'); and iii) Collimation to size of mammographic film (Reference: ACR Guidelines). 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; and 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; and iv) 6 monthly for display/PACS monitor.							

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STANDARD 14.6.2
TELERADIOLOGY
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 14.6.2.1							
The Facility that has this service shall ensure that guidelines on telemedicine from the Ministry of Health are complied with.	1. Copy of guidelines on telemedicine from the Ministry of Health are available on-site.						
CRITERION 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; and f) Contingency plan for system failure, emergency and disaster.	1. Policies and procedures for (a) to (g) are available.						
	2. Records on training						

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STANDARD 14.6.3
ULTRASONOGRAPHY
Ultrasound Diagnostic Services shall provide a comprehensive and reliable service performed by radiologists or credentialed and privileged medical practitioners/sonographers and reported by specialists.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 14.6.3.1							
The ultrasound examination shall be performed by a radiologist/trained and privileged medical practitioner or sonographer.	1. Evidence of credentialing, and privileging of staff where applicable; and						
	2. Records on training.						
CRITERION 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.	1. Evidence of credentialing and privileging of medical practitioners; and						
	2. Records on training.						
CRITERION 14.6.3.3							
Refer to (*Surat pekeliling Ketua Pengarah Kesihatan Malaysia* Bil.22/2022 dated 3/11/2022 Ruj: KKM.600-7/3/6Jld.3(12): Guidelines on Ultrasound Usage in Medical Practice). Compliance to the above Guidelines.	1. Ultrasound suite or room should meet the required specifications and at least have:						
		a. Proper sub wait waiting area for patients;					
		b. Adequate space with minimal appropriate layout dimensions to accommodate the machine, couch, staff work area, trolley/wheelchair /equipments to do ultrasound guided procedure;					
		c. Room ambience with proper dimmable lighting;					

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	d. Patient changing room/safety locker with attached /easy access to toilet; and						
	e. Dedicated Reporting area (if applicable).						

STANDARD 14.6.4 (NEW)
GENERAL RADIOGRAPHY AND FLUOROSCOPY
There are functional and safe equipment and facilities that meet the regulatory requirements for the general radiography and fluoroscopy services in the Facility. The general radiography and fluoroscopy shall be operated by a qualified radiographer/radiologist.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 14.6.4.1							
The general radiography and fluoroscopy unit shall be operated by a qualified radiographer / privileged radiology medical officer / radiologist.	1. Records on qualification of radiographer/radiology medical officer/radiologist; and						
	2. Records on training.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 14.6.4.2							
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.	1. Verification on practices during survey on adherence to relevant Regulations and guidelines.						
CRITERION 14.6.4.3							
The general radiography and fluoroscopy 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).	1. Certification from Class H license holder; and						
	2. Facilities and equipment comply with relevant Act, Regulations and standards.						
CRITERION 14.6.4.4							
All general radiography and fluoroscopy examinations shall be interpreted and reported by radiologist / privileged radiology medical officer. All general radiography and fluoroscopy examinations may be interpreted by the specialists in their areas of expertise.	1. Evidence of credentials of radiologist (Registration with National Specialist Register); and						
	2. Sampling of general radiography and fluoroscopy examination reports.						
CRITERION 14.6.4.5							
There are policies and procedures addressing the safety, operations and maintenance of the general	1. Policies and procedures on safety, operations and maintenance of the general radiography and fluoroscopy equipment; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
radiography and fluoroscopy equipment.	2. Verification on practices during survey on compliance with policies and procedures.						
CRITERION 14.6.4.6							
Documented indications and justifications are available for the use general radiography and fluoroscopy as deemed by the services.	1. Indications for general radiography and fluoroscopy are available and documented in patient's medical record.						
CRITERION 14.6.4.7							
There are policies / guidelines for the handling of the following patients: a) Infants and children; b) Pregnant patient; c) Infectious disease patients; and d) Polytrauma patients.	1. Policies / Guidelines for the handling of patients as indicated in (a) to (d)						
CRITERION 14.6.4.8							
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.	1. Records on monitoring of general radiography and fluoroscopy by medical physicist are available.						

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STANDARD 14.6.5 (NEW)
DENTAL RADIOGRAPHY
Dental radiography is inclusive of cone-beam computed tomography (CBCT). There are functional and safe equipment and facilities that meet the regulatory requirements for the dental radiography services in the Facility.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 14.6.5.1							
The dental radiography shall be operated by a privileged and trained dental practitioner/ personnel. (Refer to Guidelines on Radiation Safety in Dentistry by Malaysian Dental Council 2nd Edition Nov 2010). (Refer to National Radiology Services Operational Policy MOH 2019).	1. Records on qualification of radiographer;						
	2. Records on training; and						
	3. Letter of authorization for competency or privileging for dental practitioner / dental technician /operator to handle the intraoral machine.						
CRITERION 14.6.5.2							
All dental radiography shall be interpreted and reported by radiologist/qualified dental practitioner.	1. Evidence of credentials of radiologist / qualified dental practitioner (Registration with National Specialist Register) /						
CRITERION 14.6.5.3							
Documented indications and justifications are available for the use dental radiography as deemed by the services.	1. Indications for dental radiography are available and documented in patient's medical record.						

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STANDARD 14.6.6
MOBILE RADIOGRAPHY AND MOBILE C-ARM EXAMINATION
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 / radiologist.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 14.6.6.1							
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.	1. Certificate for static units by Class H license holder; and						
	2. Facilities and equipment comply with relevant Act, Regulations and standards.						
CRITERION 14.6.6.2							
All C-arm shall be operated by a qualified radiographer / privileged radiology medical officer / radiologist.	1. Records on qualification of radiographer/medical officer/radiologist; and						
	2. Verification on practices during survey						
CRITERION 14.6.6.3							
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.	1. Facilities comply with relevant Act, Regulations and standards.						
	2. Records on monitoring on radiation scatter by the appropriately qualified personnel/agency.						
CRITERION 14.6.6.4							
When mobile x-rays are performed in the wards, efforts should be made to ensure that	1. Standard operating procedures for using of mobile radiography in the wards; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
the neighbouring patients are protected adequately from scatter radiation.	2. Verification on practices during survey.						
CRITERION 14.6.6.5							
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.	1. Availability of standard operating procedures for mobile radiography and fluoroscopy in other locations; and						
	2. Verification on practices during survey.						
CRITERION 14.6.6.6							
There are guidelines on the handling, transport and storage of mobile x-ray machines and C-Arm machine and their accessories.	1. Availability of guidelines on the handling, transport and storage of mobile x-ray machines and C-Arm machine and their accessories; and						
	2. Verification on practices during survey.						

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STANDARD 14.6.7
BONE MINERAL DENSITOMETRY
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 14.6.7.1							
The room used for Bone Densitometry 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).	1. Certification from Class H license holder; and						
	2. Facilities and equipment comply with relevant Act, Regulations and standards.						
CRITERION 14.6.7.2							
Bone densitometry examination shall be performed by a qualified radiographer. The radiographer shall be adequately trained, credentialed and privileged.	1. Evidence of credentialing and privileging of the radiographer; and						
	2. Records on training.						
CRITERION 14.6.7.3							
There is evidence that the competency of the radiographer performing the examination is assessed by performing the precision testing.	1. Documentation of competency test.						

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STANDARD 14.6.8
MAMMOGRAPHY
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 mammograms shall report on the mammogram images. The facilities and equipment for mammography examinations including relevant AI software shall be safe and routine Quality Control is performed to ensure reliable results.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 14.6.8.1							
Mammography shall be performed by a qualified female radiographer. The mammographer shall be adequately trained, credentialed and privileged.	1. Evidence of credentialing and privileging of relevant staff; and						
	2. Records on training.						
CRITERION 14.6.8.2							
All mammography shall be interpreted and reported by radiologist. All mammography may be interpreted by the specialists in their areas of expertise.	1. Evidence of credentials of radiologist (Registration with National Specialist Register); and						
	2. Sampling of mammography report.						
CRITERION 14.6.8.3							
There is evidence that the mammographers and the radiologists reporting the mammogram attend regular relevant continuing medical education (CME).	1. Records on continuing medical education for relevant staff.						
CRITERION 14.6.8.4							
The mammographer responsible for quality control (QC) is specifically trained to perform	1. Documentation of QC test; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
routine QC tests. The results are used to troubleshoot and for quality improvement.	2. Evidence of quality improvement done.						
CRITERION 14.6.8.5 (CORE)							
The mammograms produced are audited following the Perfect, Good, Moderate and Inadequate (PGMI) classifications with evidence of documentation.	1. Documentation on PGMI audits.						

STANDARD 14.6.9
COMPUTED TOMOGRAPHY (CT)
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. All CT examinations including usage of relevant AI software shall be interpreted and reported by a radiologist.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 14.6.9.1							
Computed Tomography (CT) examination shall be performed by a qualified radiographer. The radiographer shall be adequately trained, and privileged.	1. Evidence of privileging of relevant staff; and						
	2. Records on training.						
CRITERION 14.6.9.2							
Imaging personnel and the facilities shall adhere to regulations and guidelines regarding the use of ionizing radiation, e.g. Atomic Energy	1. Verification on practices during survey on adherence to relevant Regulations and guidelines.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Licensing Act (Act 304), Atomic Energy Licensing Board (AELB), and Atomic Energy Licensing (Basic Safety Radiation Protection) Regulation 2010.							
CRITERION 14.6.9.3							
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).	1. Certification from Class H license holder; and						
	2. Facilities and equipment comply with relevant Act, Regulations and standards.						
CRITERION 14.6.9.4							
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	1. Evidence of credentials of radiologist (Registration with National Specialist Register); and						
	2. Sampling of CT scan examination reports.						
CRITERION 14.6.9.5							
There are policies and procedures addressing the safety, operations and maintenance of the CT scan equipment.	1. Policies and procedures on safety, operations and maintenance of the CT scan equipment; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	2. Verification on practices during survey on compliance with policies and procedures.						
CRITERION 14.6.9.6							
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.	1. Indications for CT scan are available and documented in patient's medical record.						
CRITERION 14.6.9.7							
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; and k) Dead bodies.	1. Guidelines for the handling of patients as indicated in (a) to (k)						
CRITERION 14.6.9.8							
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.							

STANDARD 14.6.10 (NEW)
POSITRON EMISSION TOMOGRAPHY - COMPUTED TOMOGRAPHY (PET-CT) REPORTING

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 14.6.10.1							
All PET-CT scan examinations shall be interpreted and reported by privileged radiologist/medical practitioners. All PET-CT scan examinations may be interpreted by the specialists in their areas of expertise.	1. Evidence of credentials of privileged radiologist/medical practitioner (Registration with National Specialist Register); and						
	2. Sampling of PET-CT scan examination reports.						
CRITERION 14.6.10.2							
Documented indications and justifications are available for the use of PET- CT scan, as deemed by the services.	1. Indications for PET-CT scan are available and documented in patient's medical record.						

STANDARD 14.6.11
MAGNETIC RESONANCE IMAGING (MRI)
MRI shall be performed by a qualified, trained, and privileged radiographer. All MRI examinations including usage of relevant AI software shall be interpreted and reported by a radiologist. There are policies and procedures addressing the safety, operations and maintenance of the MRI equipment.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 14.6.11.1							
Magnetic Resonance Imaging (MRI) examination shall be performed by a qualified radiographer. The radiographer	1. Evidence of privileging of radiographer; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
shall be adequately trained, and privileged.	2. Records on training.						
CRITERION 14.6.11.2							
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.	1. Evidence of credentials of radiologist (Registration with National Specialist Register); and						
	2. Sampling of MRI examination reports.						
CRITERION 14.6.11.3 (CORE)							
There are policies and procedures addressing the safety, operations and maintenance of the MRI equipment.	1. Policies and procedures for safety, operations and maintenance of the MRI equipment;						
	2. MRI suite with access control , which is to comply with the IAEA MRI Safety protocol and National Radiology Services Operational Policy 2019, Medical Development Division MOH Malaysia);						
	3. Verification on practices during survey;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	4. Periodic CME to all department staffs , hospital staffs, ancillary and maintenance workers/staff with documented evidence on their basic knowledge on MRI safety and compliance; and						
	5. Check on ancillary and maintenance workers/staff on their knowledge of safety and compliance.						
CRITERION 14.6.11.4							
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; and l) Dead bodies.	1. Availability of guidelines for handling of patients as indicated in (a) to (l) for MRI examination; and						
	2. Verification on practices during the survey.						
CRITERION 14.6.11.5							
There shall be procedures for handling of emergencies, e.g. quenching, fire outbreak, accidents in the magnet room etc.	1. Availability of procedures on handling of clinical and non-clinical emergencies.						
CRITERION 14.6.11.6							

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
There shall be provision for MRI compatible patient and staff safety equipment.	1. Availability of MRI compatible equipment.						

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STANDARD 14.6.12

ANGIOGRAPHY AND INTERVENTIONAL RADIOLOGY

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. All angiography examinations including usage of relevant AI software shall be interpreted and reported by privileged radiologist.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 14.6.12.1							
Angiography examinations shall be performed by privileged radiologist, assisted by radiographer and nurses.	1. Evidence of privileging of radiologist/relevant staff; and						
	2. Records on training.						
CRITERION 14.6.12.2							
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; and g) Radiation safety and dose monitoring.	1. Specific policies and procedures which include but not limited to items (a) to (g); and						
	2. Verification on practices during survey on compliance with policies and procedures.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 14.6.12.3							
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.	1. Verification on practices during survey on compliance to relevant Regulations and guidelines.						
CRITERION 14.6.12.4							
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.	1. Certification from Class H license holder;						
	2. Facilities and equipment comply with relevant Act, Regulations and standards; and						
	3. Room to be equipped with HEPA (High Efficiency Particulate Air) filter.						
CRITERION 14.6.12.5							
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.	1. Evidence of privileging of radiologist;						
	2. Records on training; and						
	3. Sampling of angiography reports.						
CRITERION 14.6.12.6 (CORE)							
There is evidence of special handling and compliance with policies / guidelines to ensure patient and staff safety;	1. Availability of policies / guidelines for handling of (a) – (j), including collaboration with nuclear medicine team regarding handling and disposal of radiopharmaceutical agent / waste and collaboration with						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
a) Critically ill patients or on ventilator; b) Infants and children; c) Patients with special needs d) Pregnant patients; 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), cytotoxic drugs and other items; and j) Complication of diagnostic and therapeutic interventional radiological procedures.	pharmacy department regarding storage and disposal of cytotoxic drugs; and						
	2. Verification on practices during survey on compliance with policies and procedures.						
CRITERION 14.6.12.7 (CORE)							
Support services such as anaesthetic and critical care services, emergency and resuscitation equipment are easily accessible.	1. Evidence of access to anaesthetic and critical care services, emergency and resuscitation equipment						

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STANDARD 14.6.13 (NEW)
FORENSIC RADIOLOGY
The Facility ensures that all forensic radiology examinations are performed by adequately trained and privileged radiographers/radiologists. All the forensic radiology examinations including usage of relevant AI software shall be interpreted and reported by privileged radiologists. Forensic radiological examination shall be requested by Forensic team.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 14.6.13.1							
All forensic radiology examination shall be performed by a qualified radiographer/radiologist. The radiographer/radiologist shall be adequately trained, and privileged.	1. Evidence of privileging of relevant staff; and						
	2. Records on training.						
CRITERION 14.6.13.2							
All forensic radiology examinations shall be interpreted and reported by privileged radiologist. All CT scan examinations may be interpreted by the specialists in their areas of expertise.	1. Evidence of credentials of privileged radiologist (Registration with National Specialist Register); and						
	2. Sampling of forensic radiology examination reports.						
CRITERION 14.6.13.3 (CORE) (NEW)							
Policy and procedure on the handling and imaging of deceased body and body parts shall conform to the relevant standards to preserve the chain of custody especially in police cases. (Refer to National Radiology Services Operational Policy, MOH First Edition 2019).	1. All Forensic Imaging must be requested by general Pathologist/Forensic Pathologist or Privileged Forensic Medical Officer. All imaging must have signed consent from either the clinicians/ next of kin or from police order;						
	2. General radiography on deceased bodies/body parts shall be performed at designated area or location (i.e., mortuary);						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	3. Handling of deceased body/body parts shall be discrete and are the responsibility of the forensic or Mortuary staffs; and						
	4. All imaging data to be confidential with limited access.						
CRITERION 14.6.13.4 (NEW)							
In centre or hospital with no dedicated post mortem CT, the general Pathologist/Forensic Pathologist or Privileged Forensic Medical Officer is responsible to arrange for the deceased body /body parts to be performed at the nearest hospital with PMCT service or under the hospital cluster system service.	1. Written of policies and procedures						
	2. Record of registry						

STANDARD 14.6.14
PICTURE ARCHIVING AND COMMUNICATION SYSTEM (PACS)
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 14.6.14.1							
There shall be adequate provisions with regards to the secure use, access and	1. Policies and procedures on secure use, access and maintenance of the PACS; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
maintenance of the Picture Archiving and Communications System (PACS), both within and outside the Radiology Services/Department.	2. Verification on practices during survey.						
CRITERION 14.6.14.2							
There is a policy to ensure safety and confidentially of images archived.	1. Policy on safety and confidentially of images archived; and						
	2. Verification on practices during survey.						

STANDARD 14.6.15
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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 14.6.15.1							
The darkroom or area/equipment shall be equipped with an effective exhaust system and adequate ventilation.	1. Adequate exhaust and ventilation systems in the darkroom area; and						
	2. Odour-free environment.						
CRITERION 14.6.15.2							
The Radiology Services shall ensure safety precautions are taken to avoid accidental light exposure to films	1. Provision for accidental light exposure such as:						
	a. Light tight single or double door;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	b. Door bell; and						
	c. Darkroom safe light.						
CRITERION 14.6.15.3							
Existing facilities ensure safety aspects of staff	1. Clutter-free room for safe movement of staff;						
	2. General cleanliness of the room; and						
	3. Observation on safety aspects of darkroom during survey.						

STANDARD 14.6.16
DISPOSAL OF CHEMICAL WASTE
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 14.6.16.1							
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.	1. Standard operating procedures on storage and disposal of chemical waste; and						
	2. Verification on practices during survey						

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SERVICE SUMMARY	
OVERALL RATING :	
OVERALL RISK :	

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SERVICE STANDARD 15: PATHOLOGY SERVICES

PREAMBLE

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.

TOPIC 15.1
ORGANISATION AND MANAGEMENT

STANDARD 15.1.1
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.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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 are measurable in line with the Facility statements available, endorsed and dated;						
	3. Evidence of planned reviews of the above statements (at least once in 3 years or in the event of any major changes);						
	4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc); and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.						
CRITERION 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; and 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.	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; and						
	3. The organisation chart is revised when there is a major change in any of the items (e)(i) to (iv).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Minutes are accessible, disseminated and acknowledged by the staff;						
	2. Attendance list of members with adequate representation of the service;						
	3. Frequency of meetings as scheduled; and						
	4. Discussion and resolutions are implemented.						
CRITERION 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.	1. Minutes of Facility-wide management meeting;						
	2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service; and						
	3. Approved budget and resources.						
CRITERION 15.1.1.5							
The Head of the Pathology Services is involved in the appointment and/OR assignment of staff	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; and						
	5. Duty roster.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Credentials and job description of Head of Pathology Services.						
CRITERION 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: a) POCT; b) OSH; c) Pharmacy liaison; and d) Infection Control.	1. Documented evidence of interaction with the relevant staff of the facility/services.						
CRITERION 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.	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;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	e. Staff training records; and						
	f. Data on performance improvement activities, including performance indicators.						
CRITERION 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; i) Staff closely supervised by Person In Charge (PIC) of POCT at each location; and ii) Appropriate instructions of operations of the services by Pathology Services	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;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
c) The equipment is properly maintained and quality control is carried out and documented; and d) Suggest to established point of care testing (POCT) committee at facility level.	6. Record on monitoring by laboratory staff; and						
	7. List of Person In Charge (PIC) according to location.						
CRITERION 15.1.1.10							
The Head of Services shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	1. Documented and approved BCP for unanticipated situations;						
	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment.						
	3. Clear actions and staff responsibilities during disruption;						
	4. Record of drills or tests, with follow-up actions, if conducted; and						
	5. Review of Risk Register.						

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STANDARD 15.1.2

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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 15.1.2.1							
The external providers of the Pathology Services shall conform to all relevant MSQH Standards of Accreditation.	1. The off-site laboratory shall be MS ISO 15189 accredited; and						
	2. There is written agreement between the external service provider and the Facility.						
CRITERION 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;	1. There is written agreement with the external service provider and the Facility specifying items (a) to (h).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
g) arrangements for after-hours and emergency work; and h) Quality systems shall be in place, which include Internal Quality Control (IQC), External Quality Assurance (EQA), monitoring turnaround time (TAT), accreditation status.							

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TOPIC 15.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD 15.2.1
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.
***Refer: Departmental Policy of Pathology Services in Ministry of Health, Malaysia**

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 15.2.1.1 (CORE)							
The direction and supervision of the services shall be by the pathologist. There is evidence that the pathologist and/or medical practitioner is actively practicing as evidenced by: a) Regular on-site visits and inspection of the Pathology Services; and b) Ensuring and participating in continuing medical education programme.	1. Appointment/assignment letter;						
	2. Job description;						
	3. Records on regular on-site visit and inspection; and						
	4. Documentation of participation in continuing medical education and meeting.						
CRITERION 15.2.1.2							
The Head and staff of the Pathology Services shall be individuals qualified by education, training, experience currently licensed to practice pathology to commensurate with the requirements of the various positions and complexity of the services.	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;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
All medical laboratory scientists and technologists shall be registered following the requirements of the Allied Health Professions Act.	4. National Specialist Register (NSR) for Pathologist;						
	5. Allied health Professions (AHP) registration; and						
	6. Training and competency record.						
CRITERION 15.2.1.3							
The authority, responsibilities and accountabilities of the Head of Pathology Services are clearly delineated and documented.	1. Appointment/assignment letter for Head of Service; and						
	2. Description of duties and responsibilities.						
CRITERION 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.	1. Number of staff and qualification should commensurate with workload;						
	2. Staffing pattern;						
	3. Duty roster; and						
	4. Census and statistics.						
CRITERION 15.2.1.5 (CORE)							
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;	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; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and vi) Statutory Regulations. e) Administrative and clinical functions.	4. The job description is acknowledged by the staff and signed by the Head of Service and dated.						
CRITERION 15.2.1.6							
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	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;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	g. Confidentiality agreement;						
	h. Health screening status; and						
	i. Immunisation status.						
CRITERION 15.2.1.7							
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.	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; and						
	4. Training module.						
CRITERION 15.2.1.8							
There are continuing education activities for staff to pursue professional interests and to prepare for current and future changes in practice.	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; and						
	4. Certificate of attendance/degree/post basic training.						
CRITERION 15.2.1.9							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.	1. Continuing medical education for non-laboratory health professional staff; and						
	2. Records on attendance.						
CRITERION 15.2.1.10							
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.	1. Performance appraisal for staff including medical practitioners are completed upon probationary period and as an annual exercise.						
CRITERION 15.2.1.11							
Where applicable, the functions of the Pathology Services include undergraduate, postgraduate and other health professional education, research projects and special studies, as appropriate.	1. Memorandum of Understanding (MOU); and						
	2. Records on training.						

STANDARD 15.2.2
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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 15.2.2.1 (CORE) (NEW)							
There is a structured orientation programme for all newly appointed, contracted and outsourced staff to the Pathology	1. Policy requiring all new staff to attend a structured orientation programme;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Services including medical practitioners and for those new to specific areas that include but not limited to the following: <u>General</u> a) Vision and mission of the Facility; b) Organisation chart and reporting structure of the Facility; c) Environment and facility safety policies and procedures including sustainability practices; d) Infection control policies and procedures; e) Policies for performance management, patient safety (IPSG/MPSG) and risk management; f) Ethical practices and code of conduct including medicolegal awareness; g) Management of aggression, violence and harassment; and h) Patient and family rights. <u>Services</u> i) Goals, objectives and organisational structure of Pathology Services; j) Policies and procedures relevant to Pathology Services; k) Working instructions for patient care; and	2. There is a pathology services orientation programme with relevant topics not limited to topics covered from (a) to (q); and						
	3. Attendance list.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
l) Service continuity plan for Pathology Service in response to internal and external disasters. <u>Job-specific</u> m) Explanation of particular duties and functions; n) Explanation of the methods of assigning clinical care and the standards of clinical practice; o) Handover communication; p) Training in basic/advanced life support techniques; and q) Technology and equipment use including artificial intelligence, digital care and robotics.							

STANDARD 15.2.3 (NEW)
The Pathology Services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the pathology services staff, ensuring a safe and healthy work environment.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 15.2.3.1 (CORE)							
The Pathology Services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being. a) A health-promoting environment, e.g., stress management, burn out, staff	1. The promotion of staff well-being may involve the following:						
	a. Evidence of a health promoting environment e.g., workplace wellness programme;						
	b. Evidence of proper supervision of staff; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
engagement opportunities, workload monitoring, management of work life balance, healthy, lifestyle programmes e.g. Workplace Wellness Programs, Community-Based Health Initiatives; b) Staff shall be provided with appropriate supervision, support, and advice e.g., mentor mentee program; and c) There shall be clear procedures for the effective management of underperformance e.g., feedback on performance review or performance appraisal report.	c. Evidence of staff appraisal programme with feedback on underperformance.						
CRITERION 15.2.3.2 (CORE)							
The Pathology Services shall establish a safe mechanism for Pathology Services staff to express grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of	1. Pathology services staff suggestions and grievance reporting and processing mechanisms are available;						
	2. The resolution of workplace issues may involve the following:						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
non-retaliation in accordance with the principles of psychological safety.	a. Measures and evidence of pathology staff protection including whistleblowers against violence, bullying, and harassment e.g., awareness campaigns, anonymous reporting channel, Whistleblower policy; and						
	b. Documented policies and procedures for violence activation and pathology staff protection.						
CRITERION 15.2.3.3 (NEW)							
A system shall be created to gather services staff feedback about their workplace experience such as burnout which shall be analysed and used to make improvements that enhance the work environment, pathology services staff satisfaction, and organisation culture.	1. Pathology services staff feedback (e.g., minutes of sessions or pathology staff satisfactions survey)						
	a. Evidence of action or improvement taken.						
CRITERION 15.2.3.4 (NEW)							
The pathology services shall track sick leave and pathology services staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning	1. Evidence that workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments. The results shall be used to create focused actions that improve pathology services staff well-being, solve problems, and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	help retain pathology services employees.						

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TOPIC 15.3
POLICIES AND PROCEDURES

STANDARD 15.3.1
DEVELOPMENT, DERIVATION AND DOCUMENTATION

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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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, current standard practices and Patients and Family Rights. 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	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; and						
	4. The policies and procedures are endorsed and dated.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and 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.							
CRITERION 15.3.1.2 (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.	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; and						
	3. Documented cross departmental policies.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 15.3.1.3							
Current policies and procedures are communicated to all staff.	1. Training and briefing on the current policies and procedures/Minutes of meetings; and						
	2. Circulation list and acknowledgement.						
CRITERION 15.3.1.4							
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.	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.						
CRITERION 15.3.1.5							
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; and h) Identification of the nature of the specimen on the request form and clear labelling of	1. Documented policies and procedures relating to requests for laboratory tests which include items listed (a) to (h).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
specimens requiring precautionary handling.							
CRITERION 15.3.1.6							
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.	1. Laboratory User Manual/User guide is available in hard/softcopy;						
	2. Distribution list of item (1); and						
	3. Verification of practice during survey.						
CRITERION 15.3.1.7							
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; and b) There are written policies determining the length of time for which reports and specimens are retained.	1. Complete records for specimens received and forwarded to other laboratories; and						
	2. Policies determining the length of time for which reports and specimens are retained.						
CRITERION 15.3.1.8							
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; and b) Report/forms/results are designed to facilitate	1. Evidences of (a) and (b) in patient's medical record.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
comparison of sequential tests/reports.							
CRITERION 15.3.1.9							
There is provision for immediate communication of results with critical range.	1. Policy on management of critical laboratory results; and						
	2. Evidence of communication of the critical level to the requesting medical practitioner/specialist/unit/ward.						
CRITERION 15.3.1.10							
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 report shall follow with minimum delay; and 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; and v) Date and time of receipt.	1. Standard operating procedures for releasing the result;						
	2. Copy of laboratory report in patient's medical record; and						
	3. Records on (c)(i) to (c)(v).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 15.3.1.11							
Frozen section reports are transmitted directly to the surgeon concerned and followed by a written report	1. Evidence of communication with respective surgeon; and						
	2. Written report in patient's medical record.						
CRITERION 15.3.1.12							
There are written safety procedures specific to Pathology Services.	1. Documented safety procedures specific to the Pathology Services.						
CRITERION 15.3.1.13							
There is evidence that all pathology staff practice Standard Precautions and Safety Guidelines.	1. Records on training on Standard Precautions and Safety Guidelines; and						
	2. Compliance of Standard Precautions and Safety Guidelines.						
CRITERION 15.3.1.14							
There is a manual on pathology hazards and safety.	1. Authorised and dated Pathology Safety Manual.						

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TOPIC 15.4
FACILITIES AND EQUIPMENT

STANDARD 15.4.1
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.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 15.4.1.1							
The office is separated from the technical laboratory area.	1. On-site observation of office space complies with the above; and						
	2. Layout of laboratory as per set requirements.						
CRITERION 15.4.1.2							
There are designated areas for handling potentially hazardous specimens.	1. Designated areas includes, but not limited to:						
	a. Receiving area;						
	b. Analytical area;						
	c. Storage;						
	d. Waste; and						
	e. Dispatch if applicable.						
CRITERION 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	1. On-site observation evidenced on:						
	a. Adequately spaced work benches; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
equipment in accordance with manufacturer's recommendation and safety regulations.	b. Equipment arrangement ensures safety and efficiency of the laboratory's operation.						
CRITERION 15.4.1.4							
There are adequate and proper storage areas of reagents, tissue specimens, consumables and other materials	1. On-site observation evidenced on:						
	a. Adequate storage areas; and						
	b. Designated storage area for reagents, tissue specimens, consumables and other materials.						
CRITERION 15.4.1.5							
There are separate and suitable stores for inflammable solvents and acid.	1. Separate storage for inflammables and acids according to set regulations.						
CRITERION 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.	1. Availability of:						
	a. Emergency shower;						
	b. Eye wash;						
	c. Locker facilities; and						
	d. Storage for protective clothing.						
CRITERION 15.4.1.7							
There is suitable, adequate and safe provision for air conditioning, ventilation, lighting, power,	1. Provisions for (a) to (f) are available on-site.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and f) Regular supply of distilled and deionised water for laboratory use.							
CRITERION 15.4.1.8 (CORE)							
The pathology equipments are appropriate and adequate to meet the demands of the service and are properly maintained.	1. Adequate equipment;						
	2. Appropriate equipment commensurate with the scope of services provided;						
	3. Proper equipment maintenance; and						
	4. Back-up system.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Adequate and appropriate data processing storage;						
	2. Easy retrieval of data;						
	3. Appropriate communication facilities; and						
	4. Secured system for result or report transmission.						
CRITERION 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.	1. User training records;						
	2. Competency assessment record;						
	3. Letter of authorisation; and						
	4. List of staff trained and privileged to operate and maintain specialised equipment.						
CRITERION 15.4.1.11							
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); and						
	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.						
CRITERION 15.4.1.12							
	1. Record of equipment inventory;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Inventory of equipment, reagents and consumables shall be maintained.	2. Record of reagent inventory; and						
	3. Record of consumable inventory.						
CRITERION 15.4.1.13							
Each equipment/instrument has a logbook and maintenance records and these shall be made available when required.	4. Equipment/Instrument logbook; and						
	5. Equipment/Instrument maintenance record.						
CRITERION 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.	1. Planned Preventive Maintenance records such as schedule, stickers, etc;						
	2. Planned Replacement Programme where applicable;						
	3. Complaint records; and						
	4. Asset inventory.						
CRITERION 15.4.1.15							
There is evidence of general cleanliness in the laboratory.	1. Good housekeeping is evidenced; and						
	2. Cleaning schedule.						
CRITERION 15.4.1.16							
There are proper facilities for the disposal of biohazard material as either effluent or containerised material.	1. Proper disposal of biohazard material as containerised material or effluent according to regulations evidenced on-site.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 15.4.1.17 (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care.						

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TOPIC 15.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 15.5.1
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.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 15.5.1.1							
There are periodical 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; and g) Innovation.	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; and						
	5. Records on innovation if available.						
CRITERION 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.	1. Designated officer or committee assigned for performance improvement activities; and						
	2. Designated safety officer or committee to monitor laboratory safety.						
CRITERION 15.5.1.3 (CORE)							
The Head of the Pathology Services shall ensure that the staff	1. System for incident reporting is in place, which include:						

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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.	a. Policy on incident reporting;						
	b. Methodology of incident reporting;						
	c. Register/records of incidents; and						
	d. Policy on incident reporting.						
	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; and						
	8. Feedback given to staff regarding incident reporting.						
CRITERION 15.5.1.4 (CORE)							
There is tracking and trending of specific performance indicators that covers the following:	1. Specific performance indicators monitored;						

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a) Timeliness of urgent requests; b) Rejection rate of specimens (Target: <1%).; and c) Notification of critical results. Targets of performance indicators shall meet patient care need of the Facility.	2. Records on tracking and trending analysis; and						
	3. Remedial measures taken where appropriate.						
CRITERION 15.5.1.5							
The Pathology Services shall have quality control programme for all tests provided.	1. Internal Quality Control (IQC) Programme; and						
	2. External Quality Assurance (EQA) Programme.						
CRITERION 15.5.1.6							
The results of the internal and external quality programmes shall be available and readily understood by relevant staff.	1. Evidence of participation in IQC and EQA;						
	2. Performance reviewed; and						
	3. Documented evidence of discussion.						
CRITERION 15.5.1.7							
There shall be evidence of corrective and preventive actions for any shortfall in quality.	1. Evidence of corrective actions; and						
	2. Evidence of preventive actions.						
CRITERION 15.5.1.8							
Pathology staff shall participate in clinical audit activities with other clinical specialties.	1. Evidence of participation in clinical audit activities with other services, i.e. mortality and morbidity audits.						
CRITERION 15.5.1.9 (NEW)							
The Services participates in the Facility's safety culture	1. Safety Culture Survey for staff						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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assessment. The results are utilized by Service leadership to inform and guide efforts to improve the culture of safety within the Service.							
CRITERION 15.5.1.10							
Feedback on results of safety and performance improvement activities are regularly communicated to the staff to promote transparency, shared learning, and active engagement in improvement initiatives.	1. Results of safety and performance improvement activities are accessible to staff through education sessions, meetings and digital communications.						
CRITERION 15.5.1.11							
Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.	1. Documentation on performance improvement activities and performance indicators.						
	2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						

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SERVICE SUMMARY	
OVERALL RATING :	-
OVERALL RISK :	-

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SERVICE STANDARD 16 : BLOOD TRANSFUSION SERVICES

PREAMBLE

These services may include blood donation, blood component preparation, screening and release of blood and blood components, blood inventory management, distribution management; and immuno-haematology and clinical transfusion services which cover pre-transfusion testing, antibody screening and identification, and investigation of transfusion reaction.

TOPIC 16.1
ORGANISATION AND MANAGEMENT

STANDARD 16.1.1

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 Blood Transfusion Services shall be a medical practitioner with training and experience in blood transfusion services.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

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CRITERION 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.	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 are measurable in line with the Facility statements available, endorsed and dated;						
	3. Evidence of planned reviews of the above statements (at least once in 3 years or in the event of any major changes);						
	4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc.); and						

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	5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.						
CRITERION 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; and d) Is revised when there is a major change in any of the following: i) Organisation; ii) Functions; iii) Reporting relationships; and iv) Staffing patterns.	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; and						
	3. The organisation chart is revised when there is a major change in any of the items (d) (i) to (iv).						
CRITERION 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,	1. Minutes are accessible, disseminated and acknowledged by the staff;						
	2. Attendance list of members with adequate representation of the service;						
	3. Frequency of meetings as scheduled; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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communicated to all staff of the service and implemented.	4. Discussion and resolutions are implemented.						
CRITERION 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.	1. Minutes of Facility-wide management meeting;						
	2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service; and						
	3. Approved budget and resources.						
CRITERION 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 Person In Charge (PIC)/appointed senior clinician and members include representatives from Blood Transfusion Services and main clinical services with significant transfusion activities; and b) Has Terms of Reference of the Transfusion Committee that shall include to: i) HTC meeting is conducted at least once	1. Letters of appointment/assignment;						
	2. Terms of Reference (TOR) of Transfusion Committee; and						
	3. Minutes of Transfusion Committee meeting.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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a year to review all the related activities; ii) Patient Blood Management policies adapted to local clinical activities; iii) Blood transfusion policies adapted to the local clinical activities; iv) Regular review of patient blood management and blood transfusion practices; v) Analysis of any adverse events due to blood donation and transfusion; vi) Any preventive and corrective measures if necessary; and vii) All staff involved in transfusion chain receive adequate training.							
CRITERION 16.1.1.6							
The Head of Blood Transfusion Services is involved in the appointment and/OR assignment of the staff.	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. Record of qualification; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	6. Duty roster.						
CRITERION 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. If blood collection activities are carried out within the Facility, appropriate donor statistics and records shall be maintained as above.	1. Records are available but not limited to the following:						
	a. Workload/census;						
	b. Annual report;						
	c. Accident/incident/complaint 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, customer satisfaction survey; and						
	i. Monitor implementation of PBM (Patient Blood Management)- Continuous Medical Education, detection and awareness of anemia.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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CRITERION 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: a) Storage. b) Transport.	1. Records are available for the following:						
	a) Training and competency records;						
	b) Equipment maintenance records;						
	c) Records on quality control measures; and						
	d) Records on quality monitoring.						
CRITERION 16.1.1.9							
The Governing Body shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	1. Documented and approved BCP for unanticipated situations;						
	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment.						
	3. Clear actions and staff responsibilities during disruption;						
	4. Record of drills or tests, with follow-up actions, if conducted; and						

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	5. Review of Risk Register.						

STANDARD 16.1.2

Facilities that do not provide a full range of Blood Transfusion Services shall arrange with an external source to provide the services needed.

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CRITERION 16.1.2.1							
The Blood Transfusion Services provided by an external source shall comply with all relevant MSQH Standards of Accreditation.	1. Certification of accreditation for the following:						
	a. Department of Standards Malaysia (ISO MS 15189);						
	b. MSQH Standards of accreditation; and						
	c. Compliance to current Good Manufacturing Practice (cGMP) and Good Distribution Practice (cGDP) standards.						
CRITERION 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;	1. There is written agreement with the external service provider and the Facility specifying items (a) to (f).						

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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; and f) The external service provider shall have a quality system in place.							

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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. The day-to-day operations of the service may be delegated to a suitably qualified and experienced officer, supported by appropriately qualified staff.

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CRITERION 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. 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; and b) Ensuring and participating in continuing medical education programme.	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 training and competency assessment;						
	6. Duty roster; and						
	7. Documentation of participation in continuing medical education and meetings.						
CRITERION 16.2.1.2							
The authority, responsibilities and accountabilities of the Head of	1. Appointment/assignment letter for Head of Service; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Blood Transfusion Services are clearly delineated and documented.	2. Description of duties and responsibilities.						
CRITERION 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.	1. The medical and allied health staff in Blood Transfusion Services shall have a:						
	a. Valid professional certification such as APC, MAHPC; and						
	b. Current assigned duty roster.						
CRITERION 16.2.1.4 (CORE)							
Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the need of the services. **Notes/Explanations:** Staff are 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.	1. Number of staff and qualification commensurate with workload;						
	2. Staffing pattern;						
	3. Duty roster; and						
	4. Census and statistics.						
CRITERION 16.2.1.5 (CORE)							
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;	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;						

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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; and vi) Statutory Regulations. e) Administrative and clinical functions.	3. Relevant privileges granted where applicable; and						
	4. The job description is acknowledged by the staff and signed by the Head of Service and dated.						
CRITERION 16.2.1.6							
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	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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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	f. Leave record;						
	g. Incidents at work;						
	h. Confidentiality agreement;						
	i. Health screening status; and						
	j. Immunisation status						
CRITERION 16.2.1.7							
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.	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; and						
	5. Training module.						
CRITERION 16.2.1.8							
There are continuing education activities for staff including medical practitioners to pursue professional interests and to prepare for current and future changes in practice.	1. Training calendar includes in-house/external courses/ workshop/conferences;						
	2. Contents of training programme;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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	3. Training records on continuing education activities are kept and maintained for each staff including training in life support; and						
	4. Certificate of attendance/degree/post-basic training.						
CRITERION 16.2.1.9							
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.	1. Performance appraisal for staff including medical practitioners are completed upon probationary period and as an annual exercise.						
CRITERION 16.2.1.10							
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 Patient Blood Management, blood transfusion and related fields.	1. Records on continuing education activities for non-transfusion services health professional staff; and						
	2. Records on attendance.						
CRITERION 16.2.1.11							
The functions of Blood Transfusion Services include continuous professional development, where relevant, as well as research projects and special studies, as appropriate.	1. Records on training; and						
	2. Records on research projects and special studies if available.						

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STANDARD 16.2.2
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.

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CRITERION 16.2.2.1 (CORE) (NEW)							
There is a structured orientation programme for all newly appointed, contracted and outsourced staff to the Services that include but not limited to the following: <u>General</u> a) Vision and mission of the Facility; b) Organisation chart and reporting structure of the Facility; c) Environment and facility safety policies and procedures including sustainability practices; d) Infection control policies and procedures; e) Policies for performance management, patient safety (IPSG/MPSG) and risk management; f) Ethical practices and code of conduct including medicolegal awareness; g) Management of aggression, violence and harassment; and h) Patient and family rights <u>Services</u>	1. Policy requiring all new staff to attend a structured orientation programme;						
	2. There is Services orientation programme with relevant topics not limited to topics covered from (a) to (q); and						
	3. Attendance list.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
i) Goals, objectives and organisational structure of Services; j) Policies and procedures relevant to Services; k) Working instructions for patient care; and l) Service continuity plan for Services in response to internal and external disasters. <u>Job-specific</u> m) Explanation of particular duties and functions; n) Explanation of the methods of assigning clinical care and the standards of clinical practice; o) Handover communication; p) Training in basic/advanced life support techniques; and q) Technology and equipment use including artificial intelligence, digital care and robotics.							

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STANDARD 16.2.3 (NEW)

The Blood Transfusion Services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the blood transfusion staff, ensuring a safe and healthy work environment.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 16.2.3.1 (CORE)							
The blood transfusion services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being. a) A health-promoting environment, e.g., stress management, burn out, staff engagement opportunities, workload monitoring, management of work life balance, healthy, lifestyle programmes e.g. Workplace Wellness Programs, Community-Based Health Initiatives; b) Staff shall be provided with appropriate supervision, support, and advice e.g., mentor mentee program; and c) There shall be clear procedures for the effective management of underperformance e.g., feedback on performance review or performance appraisal report.	1. The promotion of staff well-being may involve the following:						
	a. Evidence of a health promoting environment e.g., workplace wellness programme;						
	b. Evidence of proper supervision of staff; and						
	c. Evidence of staff appraisal programme with feedback on underperformance.						
CRITERION 16.2.3.2 (CORE)							
The blood transfusion services shall establish a safe mechanism	1. Blood transfusion staff suggestions and grievance reporting and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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for blood transfusion staff to express grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety.	processing mechanisms are available;						
	2. The resolution of workplace issues may involve the following:						
	a. Measures and evidence of blood transfusion staff protection including whistleblowers against violence, bullying, and harassment e.g., awareness campaigns, anonymous reporting channel, Whistleblower policy; and						
	b. Documented policies and procedures for violence activation and blood transfusion staff protection.						
CRITERION 16.2.3.3 (NEW)							
A system shall be created to gather staff feedback about their workplace experience such as burnout which shall be analysed and used to make improvements that enhance the work environment, staff satisfaction, and organisation culture.	1. Staff feedback (e.g., minutes of sessions or staff satisfactions survey);						
	a. Evidence of action or improvement taken.						
CRITERION 16.2.3.4 (NEW)							
The blood transfusion services shall track sick leave and blood transfusion staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning	1. Evidence that workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments. The results shall be used to create focused actions that improve blood transfusion staff well-						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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	being, solve problems, and help retain blood transfusion employees.						

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TOPIC 16.3
POLICIES AND PROCEDURES

STANDARD 16.3.1
DEVELOPMENT, DERIVATION AND DOCUMENTATION
There are written and dated policies and procedures that reflect current knowledge and principles of Patient Blood Management and 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 act, 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, and the Consensus Statement on Patient Blood Management, by the Ministry of Health Malaysia; available for staff reference.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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CRITERION 16.3.1.1 (CORE)							
There are written policies and procedures for each area of the Blood Transfusion Services including the Patient Blood Management (PBM) 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, current standard practices and Patients and Family Rights. 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 in	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 – predonation,						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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accordance to Patient Blood Management (PBM) d) Provision of consultative service for the medical profession and other relevant staff on the management of Iron Deficiency Anaemia (IDA), appropriate use of blood and blood products and in the selection of the laboratory investigations, their interpretation and repeat of tests if required; and 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 or whenever major changes occur.	donation and post donation including ADR (Adverse Donor Reaction);						
	9. Records on blood request forms;						
	10. Records on blood transfusion in patient medical records;						
	11. Record of Patient Blood Management (PBM) - Training record, awareness program (CME/CNE);						
	12. Records of management of look back & recall;						
	13. Record of PBM - Training record, awareness program (CME/CNE);						
	14. Standard operating procedures on transfusion – blood sampling and labelling, blood administration, management of adverse transfusion reactions; and						
	15. Training and competency records.						
CRITERION 16.3.1.2 (CORE)							
There are policies and procedures for blood donor management a) Donor declaration and consent for donation shall be obtained and maintained;	1. Policies and procedures for blood donor management include items (a) to (h);						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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~~ shall not be allowed except in special circumstances; 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; g) Management of donors with reactive donation result; and h) Management of look back & recall	2. Records of management of reactive donors;						
	3. Records of management of look back & recall;						
	4. Donation and donor database; and						
	5. Blood donation consents.						
CRITERION 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	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. Nucleic Acid Testing is performed for HIV, Hepatitis B, Hepatitis C screening.						
	4. Records on screening results.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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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.	5. Blood release records.						
CRITERION 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) Qualified equipment (installation qualification, operational qualification, performance qualification), validated and maintained shall be use. d) Regular quality control shall be carried out to ensure quality of components.	1. Standard operating procedures for blood component preparation;						
	2. Records on types of components prepared;						
	3. Records on quality control (QC) of components prepared; and						
	4. Records on equipment monitoring and maintenance.						
CRITERION 16.3.1.5 (CORE)							
There are policies and procedures for blood inventory and	1. Policies and procedures for blood inventory management include items (a) to (d);						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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distribution 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; and d) Expired and unsuitable blood and blood components shall be appropriately disposed of.	2. Records on temperature monitoring during storage and transport;						
	3. Records on discarded blood and blood components; and						
	4. Traceability records.						
CRITERION 16.3.1.6 (NEW)							
There is evidence of compliance with policies and procedures.	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.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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CRITERION 16.3.1.7 (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) 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; and d) All near misses, incorrect blood component transfused (IBCT) and ABO discrepancies shall be investigated and documented.	1. Policies and procedures for immunohaematology include items (a) to (d); 2. Records on ABO and Rh grouping for donated blood; and 3. Records on pre-transfusion testing for patient.						
CRITERION 16.3.1.8							
There are policies and procedures for Clinical Transfusion Practice and Patient Blood Management (PBM): a) Application of Good Transfusion Practice (GTP) and Patient Blood	1. Documentation of informed consent in patient's medical record; 2. Record of blood transfusion request; 3. Record of blood transfusion checklist;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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Management (PBM) principles in patient management; b) Informed consent for transfusion shall be obtained by registered medical practitioner and maintained; c) 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; 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; and vii) The specimen shall be clearly and correctly labeled.	4. Records of adverse events and near misses in relation to blood transfusion; 5. Records of management of Corrective action and Preventive Action (CAPA) and complaints; and 6. Record of reporting to NHCC.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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d) 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) Non conformances (NCs) shall be managed appropriately, documented and reported; and vi) All adverse events shall be managed appropriately,							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
documented and reported to the Transfusion Committee and National Haemovigilance Coordinating Centre (NHCC). e) All transfusion records shall be included in the patient's medical record in accordance to defined retention periods.							
CRITERION 16.3.1.9							
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.	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; and						
	3. Documented cross departmental policies.						
CRITERION 16.3.1.10							
Current policies and procedures are communicated to all staff.	1. Training and briefing on the current policies and procedures/Minutes of meetings; and						
	2. Circulation list and acknowledgement.						
CRITERION 16.3.1.11							
Copies of policies and procedures including Standard Operating Procedure Manual, protocols, guidelines, relevant Acts, Regulations, By-Laws and	1. Copies of policies and procedures including Standard Operating Procedure Manual, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Statutory requirements are accessible for staff reference.	requirements are accessible on-site for staff reference.						
CRITERION 16.3.1.12							
The following records shall be kept in accordance to defined retention periods to ensure traceability and accountability: a) Blood donation; b) Component processing; c) Blood screening; d) Inventory and distribution; and e) Immunohaematology and Clinical Transfusion	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; and						
	d. Blood issued to other facilities.						
CRITERION 16.3.1.13							
There are policies and procedures on Haemovigilance as follows: a) Adverse events relating to blood donation and transfusion; b) Look back 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.	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;						
	3. Minutes Facility Transfusion Committee on Haemovigilance; and						
	4. Record of reporting of adverse events to National Haemovigilance Coordinating Centre (NHCC).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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CRITERION 16.3.1.14							
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.	1. Standard Precautions and Safety Guidelines; and						
	2. Training records on standard precautions and safety guidelines.						

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TOPIC 16.4
FACILITIES AND EQUIPMENT

STANDARD 16.4.1
There are adequate facilities and equipment for the safe and efficient provision of Blood Transfusion Services.

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CRITERION 16.4.1.1							
Blood bank laboratories should have designated areas for different processes to ensure safety, prevent cross-contamination, and maintain workflow efficiency.	1. There are physically /functionally separated designated areas for:						
	a. Administrative functions;						
	b. Blood donor area;						
	c. Blood collection area;						
	d. Blood testing/screening;						
	e. Blood processing area;						
	f. Storage area;						
	g. Blood distribution area;						
	h. Clinical transfusion laboratory;						
	i. Ancillary area- staff rest and refreshment areas; and						
	j. Waste disposal area						
CRITERION 16.4.1.2							
Technical work (collecting, processing, testing, storing and releasing of blood and blood products) areas shall be adequately spaced out and arranged in such a way to	1. On-site observation to verify layout of facility complies with safety requirements; and						
	2. Unidirectional flow of blood donors, blood samples and blood components.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
facilitate workflow to ensure safety and efficiency.							
CRITERION 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, freezers and platelet agitators respectively; d) Temperature control of all blood refrigerators, freezers and platelet agitators shall be monitored and documented.	1. Adequate facilities and proper utilisation of space within the Facility;						
	a. Clear exit route; and						
	b. No over crowding						
	2. Adequate storage space;						
	3. Record of temperature monitoring;						
	4. Dedicated refrigerators, freezers and platelet agitators for screened and unscreened blood and blood components;						
	5. Records of alarm checks carried out for blood refrigerators, freezers and platelet agitators; and						
	6. Monitoring of expiry rate (e.g: blood component. reagent and consumables).						
CRITERION 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.	1. Standard operating procedures for disposal of reactive donations;						
	2. Records on disposal due to reactive donations; and						
	3. Separate storage area before disposal.						

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CRITERION 16.4.1.5							
There are suitably located staff facilities with locker facilities and staff are provided with appropriate personal protective clothing.	1. Appropriate Personal Protective Equipment (PPE) available; and						
	2. Staff facilities, i.e. lockers. rest area, pantries.						
CRITERION 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; and 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.	1. Provisions for items (a) to (d) are available on-site; and						
	2. Record of ambient temperature monitoring in appropriate locations such as component processing area, etc.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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CRITERION 16.4.1.7							
Equipment are appropriate and adequate to meet the scope of the services.	1. Adequate equipment; and						
	2. Appropriate equipment commensurate with the scope of services provided.						
CRITERION 16.4.1.8							
The Blood Transfusion Services shall have adequate and appropriate information management system and communication facilities.	1. Bidirectional traceability and audit trail are available.						
CRITERION 16.4.1.9 (CORE)							
Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.	1. User training records;						
	2. Competency assessment record;						
	3. Letter of authorisation; and						
	4. List of staff trained and authorised to operate specialised equipment.						
CRITERION 16.4.1.10							
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); and						
	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.						

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CRITERION 16.4.1.11							
Each equipment shall have a logbook, cleaning and maintenance record.	1. Equipment logbook;						
	2. Equipment maintenance record; and						
	3. Equipment cleaning activities.						
CRITERION 16.4.1.12							
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.	1. Planned Preventive Maintenance records such as schedule, stickers, etc;						
	2. Planned Replacement Programme where applicable;						
	3. Complaint records; and						
	4. Asset inventory.						
CRITERION 16.4.1.13							
Cleanliness in the Blood Transfusion Services shall be maintained at all times.	1. Good housekeeping is evidenced; and						
	2. Cleaning records.						
CRITERION 16.4.1.14 (CORE)							
There are proper facilities for the disposal of biohazard wastes.	1. Proper facilities for disposal of biohazard wastes.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 16.4.1.15 (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care.						

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TOPIC 16.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 16.5.1
The Head of Blood Transfusion Services shall ensure the provision of safe, quality and adequate blood and components with staff involvement in the continuous safety and performance improvement activities of the Blood Transfusion Services.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 16.5.1.1							
There are periodical 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; and g) Innovation.	1. Planned performance improvement activities include (a) to (g);						
	2. Records on performance improvement activities;						
	3. Minutes of performance improvement meetings;						
	4. Performance improvement studies; and						
	5. Records on innovation if available.						
CRITERION 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.	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; and						

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	4. Minutes of meetings.						
CRITERION 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.	1. System for incident reporting/adverse event reporting is in place, which include:						
	a. Training in incident reporting and RCA of staff;						
	b. Policy on incident/adverse event reporting;						
	c. Methodology of incident//adverse event reporting;						
	d. Register/records of incidents/adverse event; and						
	e. Reporting to relevant national program (eg: Adverse donor/transfusion event reported to National Haemovigilance Coordinating Centre).						
	2. Completed incident/adverse event 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;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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	8. Feedback given to staff regarding incident reporting; and						
	9. Risk management assessment.						
CRITERION 16.5.1.4 (CORE)							
There is tracking and trending of specific performance indicators of the following: a) Crossmatch to transfusion ration (C:T ratio) (Target: ≤ 2.0) b) Expiry rates of different blood components. (Target: Red cell: ≤2.0% and Apheresis, Platelet or plasma: 0%) c) Haemovigilance Reporting Compliance to National Haemovigilance Coordinating Centre (NHCC): Monthly **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).	1. Specific performance indicators monitored;						
	2. Records on tracking and trending analysis;						
	3. Remedial measures taken where appropriate; and						
	4. Prove of report submission to relevant national coordinating centre.						
CRITERION 16.5.1.5							
The Blood Transfusion Services shall have relevant internal quality control programme and subscribe to approved external quality assessment. The results	1. Records on Internal Quality Control (QC) and External Quality Assurance performance;						
	2. QC of tests performed; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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of the performance shall be communicated to the staff.	3. Proficiency testing (External quality assurance program).						
CRITERION 16.5.1.6 (NEW)							
The Services participates in the Facility's safety culture assessment. The results are utilized by Service leadership to inform and guide efforts to improve the culture of safety within the Service.	1. Safety Culture Survey for staff.						
CRITERION 16.5.1.7							
The feedback on results of quality assurance activities is regularly communicated to the staff.	1. Minutes of Meeting;						
	2. Staff acknowledgement documented in communication book; and						
	3. Circulation of analysis report.						
CRITERION 16.5.1.8							
Audit shall be carried out to cover processes and activities of the services.	1. Audit schedule;						
	2. Audit report;						
	3. Corrective and Preventive Action (CAPA) from Audit Findings; and						
	4. Auditor Competency Records.						
CRITERION 16.5.1.9							
A Blood Transfusion Services officer shall be appointed to monitor laboratory safety and	1. Letter of appointment;						
	2. Terms of reference; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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observance of standard precautions and safety guidelines.	3. Record of safety activities conducted.						
CRITERION 16.5.1.10							
Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff, donors and patients are preserved.	1. Documentation on performance improvement activities and performance indicators; and						
	2. Policy statement on anonymity on donors and patients involved in performance improvement activities.						

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SERVICE SUMMARY	
OVERALL RATING :	-
OVERALL RISK :	-

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SERVICE STANDARD 17: REHABILITATION MEDICINE SERVICES

PREAMBLE

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.

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.

Rehabilitation Medicine Specialist provide leadership to multidisciplinary teams concerned with optimal restoration of function via physical, psychological, social, occupational, vocational and avocational interventions.

TOPIC 17.1
ORGANISATION AND MANAGEMENT

STANDARD 17.1.1

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.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

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CRITERION 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	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 are measurable line with the Facility statements are available, endorsed and dated;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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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	3. Evidence of planned reviews of the above statements (at least once in 3 years or in the event of any major changes);						
	4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc); and						
	5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.						
CRITERION 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;	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's endorsed, dated and accessible; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
c) Is accessible to all staff and clients; and d) Is revised when there is a major change in any of the following: i) Organisation; ii) Functions; iii) Reporting relationships; and iv) Staffing patterns.	3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv)						
CRITERION 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; and 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.	1. Departmental/Service operational policies that address items (a) to (d);						
	2. Policies on patients' safety and patient and family rights;						
	3. Medical Staff By-Laws;						
	4. Evidence of involvement of medical practitioners in the formulation of policies and procedures concerning patient care;						
	5. Involvement of Head of the Service in the Medical and Dental Advisory Committee/Medical Advisory Committee and management meetings;						
	6. Communication between governing body/Head of Service and medical practitioners addressing requirement of service provision, e.g. minutes of meetings;						
	7. Proper and adequate equipment according to current standards; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	8. Patient discharge notes show evidence of follow up or referral to relevant agencies.						
CRITERION 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; and 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.	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; and						
	4. Minutes of meetings of MDAC/Management.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17.1.1.5							
There is documented evidence of multidisciplinary, interdisciplinary or transdisciplinary team management of patients led by a Rehabilitation Medicine Specialist	1. Documentation of the meetings;						
	2. Documented evidence of communication; and						
	3. Sample patient's medical records.						
CRITERION 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; and c) Involvement and provide regular input to the Hospital Management Team	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; and						
	3. Minutes of meeting of Hospital Management Team.						
CRITERION 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;	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;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
b) Human resource management and development; c) Development of policies and procedures and ensuring compliance to them; d) Facility and equipment management; and e) Safety and performance improvement activities and risk management.	4. Endorsement of policies and procedures;						
	5. Request for allocation of budget and staffing; and						
	6. Implementation of performance improvement activities.						
CRITERION 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.	1. Minutes are accessible, disseminated and acknowledged by the staff;						
	2. Attendance list of members with adequate representation of the service;						
	3. Frequency of meetings as scheduled; and						
	4. Discussion and resolutions are implemented.						
CRITERION 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; and c) Appropriate supervision and training are given to the medical practitioners concerned.	1. Logbooks;						
	2. Assessment reports; and						
	3. Training timetable, continuing medical education and attendances list.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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; and						
	f. Data on performance improvement activities, including performance indicators.						
CRITERION 17.1.1.11 (NEW)							
The Head of Services shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	1. Documented and approved BCP for unanticipated situations;						
	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment.						
	3. Clear actions and staff responsibilities during disruption;						
	4. Record of drills or tests, with follow-up actions, if conducted; and						
	5. Review of Risk Register.						

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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17.2.1.1							
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 &	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/logbooks;						
	4. Recommendations from peer/referee;						
	5. Privileging certificates, Annual Practicing Certificate (APC) and National Specialist Register (NSR) Certificates;						
	6. Availability of the list of specialised procedures requiring credentialing and privileging;						
	7. Availability of list of specialised procedures specific to the disciplines performed by medical officers; and						
	8. Process of credentialing and privileging and re-privileging by authorized committee.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and h) The recommendations of the relevant department and/or major professional services for privileges to be granted are taken into consideration.							
CRITERION 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.	1. Formal letter of assignment or certificate of privileging with stipulated timeline are issued and reviewed accordingly; and						
	2. Updated list of staff with privileges conferred is made accessible at point of care.						
CRITERION 17.2.1.3							
Clinical staff perform within the privileges conferred.	1. Verification of procedures performed by individuals at point of care within the awarded privileging rights with evidence of:						
	a. List of procedures privileged; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	b. Clinical notes.						
CRITERION 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; and 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 shall include specialization skills;						
	3. Relevant privileges granted where applicable; and						
	4. The job description is acknowledged by the staff and signed the by Head of Service and dated.						

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STANDARD 17.2.2
STAFF TRAINING, EDUCATION, APPRAISAL AND RESEARCH
The Facility and all staff shall demonstrate an ongoing commitment to continuing medical education.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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; and						
	4. Certificate of attendance/degree/post basic training.						
CRITERION 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.	1. Evidence of results of audit activities, e.g. mortality and morbidity reviews, incident reporting, etc in educational activities; and						
	2. Evidence of improvement made and learning from corrective or preventive measures from incident reports.						
CRITERION 17.2.2.3							
In a Facility where undergraduate medical, nursing and allied health training programmes are	1. Sufficient skilled trained staff to provide clinical supervision as per						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
conducted, the Facility shall ensure that there are sufficient skilled trained staff to provide clinical supervision of students.	terms of Memorandum of Understanding.						
CRITERION 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.	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; and						
	4. Training module.						
CRITERION 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.	1. Performance appraisal for staff including medical practitioners is completed upon probationary period and as an annual exercise.						
CRITERION 17.2.2.6							
Where appropriate the Facility shall endeavor to undertake clinical research using available resources.	1. Documented evidence of research activities e.g. protocol, policies, consent etc.						

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STANDARD 17.2.3
STAFFING LEVEL AND STAFF COMPETENCY
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.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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: i) Rehabilitation Physician :1:16 patients; ii) Medical Officers :1:8 patients; iii) Nurses/ Medical Assistants 1:4 patients. Preferably 1 post basic rehabilitation nurse available per shift; iv) Physiotherapist :1:6 patients; v) Occupational Therapists :1:6 patients; vi) Speech Therapists :1:6 patients; vii) Medical Social Worker :1:24 patients; viii) Clinical Psychologist:1:24 patients;	1. Documentation and planning on assignment of staff that includes but not limited to items listed (a) to (f) with evidence of:						
	a. Assignment 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; and						
	d. Duty roster.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
ix) Psychology Counsellors:1:24 patients; x) Healthcare Assistants :1:4 patients; and xi) 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; 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; and f) Dietetic and pharmacy service providers are available on site.							

STANDARD 17.2.4
STAFF ORIENTATION
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.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17.2.4.1							
There is a structured orientation programme for all newly appointed, contracted and outsourced staff to the Rehabilitation Medicine Services including medical practitioners and for those new to specific areas that include but not limited to the following: <u>General</u> a) Vision and mission of the Facility; b) Organisation chart and reporting structure of the Facility; c) Environment and facility safety policies and procedures including sustainability practices; d) Infection control policies and procedures; e) Policies for performance management, patient safety (IPSG/MPSG) and risk management; f) Ethical practices and code of conduct including medicolegal awareness; g) Management of aggression, violence and harassment; and	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 (q); and 3. Attendance list						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
h) Patient and family rights. Services i) Goals, objectives and organisational structure of Rehabilitation Medicine Services; j) Policies and procedures relevant to Rehabilitation Medicine Services; k) Working instructions for patient care; and l) Service continuity plan for Rehabilitation Medicine Services in response to internal and external disasters. Job-specific m) Explanation of particular duties and functions; n) Explanation of the methods of assigning clinical care and the standards of clinical practice; o) Handover communication; p) Training in basic/advanced life support techniques; and q) Technology and equipment use including artificial intelligence, digital care and robotics.							

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STANDARD 17.2.5 (NEW)

The Rehabilitation Medicine Services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the Rehabilitation Medicine Services staff, ensuring a safe and healthy work environment.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17.2.5.1 (CORE)							
The Rehabilitation Medicine Services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being. a) A health-promoting environment, e.g., stress management, burn out, staff engagement opportunities, workload monitoring, management of work life balance, healthy, lifestyle programmes e.g. Workplace Wellness Programs, Community-Based Health Initiatives; b) Staff shall be provided with appropriate supervision, support, and advice e.g., mentor mentee program; and c) There shall be clear procedures for the effective management of underperformance e.g., feedback on performance review or performance appraisal report.	1. The promotion of staff well-being may involve the following:						
		a. Evidence of a health promoting environment e.g., workplace wellness programme;					
		b. Evidence of proper supervision of staff; and					
		c. Evidence of staff appraisal programme with feedback on underperformance.					
CRITERION 17.2.5.2 (CORE)							
The Rehabilitation Medicine Services shall establish a safe	1. Rehabilitation Medicine Services staff suggestions and grievance						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
mechanism for Rehabilitation Medicine Services staff to express grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety.	reporting and processing mechanisms are available;						
	2. The resolution of workplace issues may involve the following:						
	a. Measures and evidence of Rehabilitation Medicine Services staff protection including whistleblowers against violence, bullying, and harassment e.g., awareness campaigns, anonymous reporting channel, Whistleblower policy; and						
	b. Documented policies and procedures for violence activation and Rehabilitation Medicine Services staff protection.						
CRITERION 17.2.5.3 (NEW)							
A system shall be created to gather Rehabilitation Medicine Services staff feedback about their workplace experience such as burnout which shall be analysed and used to make improvements that enhance the work environment, Rehabilitation Medicine Services staff satisfaction, and organisation culture.	1. Rehabilitation Medicine Services staff feedback (e.g., minutes of sessions or Rehabilitation Medicine Services staff satisfactions survey):						
	a. Evidence of action or improvement taken.						
CRITERION 17.2.5.4 (NEW)							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
The Rehabilitation Medicine Services shall track sick leave and Rehabilitation Medicine Services staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning	1. Evidence that workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments. The results shall be used to create focused actions that improve staff well-being, solve problems, and help retain employees.						

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TOPIC 17.3
POLICIES AND PROCEDURES

STANDARD 17.3.1
DEVELOPMENT, DERIVATION AND DOCUMENTATION
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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, current standard practices and Patients and Family Rights. 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.	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; and						
	4. The policies and procedures are endorsed and dated.						
CRITERION 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.	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; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Cross departmental collaboration is practiced in developing relevant policies and procedures where applicable.	3. Documented cross departmental policies						
CRITERION 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 organizational structure of the Rehabilitation Medicine 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 infectious diseases including notification of notifiable diseases; k) The responsibilities of the staff including medical	1. Documented policies and procedures that address but not limited to items (a) to (p); 2. Incident reports and actions taken as required; and 3. Policies on Code Blue, security response and Occupational Safety and Health Act with evidence of implementation process						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and p) Management of a death.							
CRITERION 17.3.1.4							
The care process shows documentary evidence of goal planning that involves team members, patients and care givers.	1. Samples of interdisciplinary records (IDR) documentation; and						
	2. Samples of family conferences documentation.						
CRITERION 17.3.1.5							
Care programmes incorporate the use of functional assessments at entry and completion of planned care programme.	1. Samples of IDR documentation; and						
	2. Samples of functional outcomes instrument used.						
CRITERION 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.	1. Patient's medical records; and						
	2. Discharge summary/referral letter						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17.3.1.7							
Evidence of facilitation of societal reintegration shall be available in the care process as shown by:admission process 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; and g) Disability certification as per PWDs registration guidelines by Department for Development of PWDs.	1. Discharge summary;						
	2. IDR documentation;						
	3. Patient's clinical notes; and						
	4. Sample referral letter with evidence of (a) to (e).						
CRITERION 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.	1. Records on training for patients and staffs addressing:						
	a. Falls; and						
	b. Transfer and handling of patients						
CRITERION 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:	1. Structured programme for inpatients undergoing active rehabilitation that include the aspects of (a) to (d);						
	2. Discharge summary;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and d) Monitoring of patient and staff falls, occupational injuries and backache.	3. IDR documentation and patient's clinical notes;						
	4. Sample referral letter;						
	5. Incident reports on falls, injuries etc of patients and staff; and						
	6. Sample of functional outcomes instrument used.						
CRITERION 17.3.1.10							
Current policies and procedures are communicated to all staff	1. Training and briefing on the current policies and procedures/Minutes of meetings; and						
	2. Circulation list and acknowledgement.						
CRITERION 17.3.1.11 (CORE)							
There is evidence of compliance with policies and procedures.	3. Compliance with policies and procedures through:						
	a. interview of staff on practices;						
	b. verify with observation on practices;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	c. results of audit on practices;						
	d. Practices in line with established policies and procedures.						
CRITERION 17.3.1.12							
Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By Laws and statutory requirements are accessible to staff.	1. Copies of relevant policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.						
CRITERION 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.	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; and						
	4. On-call roster is dated and authorized.						

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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.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17.4.1.1							
There are adequate and appropriate facilities and equipment with proper utilization of space to enable staff to carry out their professional, teaching and administrative functions.	1. Adequate and proper utilization 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; and						
	5. Absence of overcrowding.						
CRITERION 17.4.1.2							
Existing facilities shall take cognizance of the safety of staff and patients.	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;						

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	2. Adequate equipment and supplies for Rehabilitation Medicine Services, e.g. emergency trolley, functioning patient call bell, adequate PPE etc; and						
	3. Equipment should have scheduled planned preventive maintenance (PPM).						
CRITERION 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.	1. Appropriate and functioning telecommunication modalities available for daily operation and during emergencies e.g. landlines, hand phones, pagers, intercom.						
CRITERION 17.4.1.4							
All medical devices procured after gazettement of Medical Device Act 2012 shall comply with the regulations of the Acts.	1. Availability of relevant document and certificates.						

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STANDARD 17.4.2
FACILITIES AND EQUIPMENT FOR PATIENT CARE
Adequate facilities and equipment shall be available to provide safe and effective patient care.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17.4.2.1							
Facilities are suitably located to facilitate easy access and to provide an atmosphere of user, environmental and 'disabled' friendly.	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; and						
	4. Disabled friendly parking facilities						
CRITERION 17.4.2.2							
Equipment, both for emergency and non-emergency usage, shall be appropriate to the level of care.	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; and						
	2. Scheduled checking of items in emergency trolley.						
CRITERION 17.4.2.3							
The wards where inpatient rehabilitation care is undertaken shall be equipped with the following:	1. Inpatient rehabilitation care facilities are appropriately equipped and include items listed (a) to (e).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; 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; and f) Ceiling mounted or mobile hoist for safe transfer.							
CRITERION 17.4.2.4							
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); and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	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.						
CRITERION 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.	1. Planned Preventive Maintenance records, such as schedule, stickers, etc;						
	2. Planned Replacement Programme where applicable;;						
	3. Complaint records; and						
	4. Asset inventory.						
CRITERION 17.4.2.6							
Where specialized equipment is used, there is evidence that only staff who are trained and authorized by the Facility operate such equipment.	1. User training records;						
	2. Competency assessment record;						
	3. Letter of authorization privileging; and						
	4. List of staff trained and authorized privileged to operate specialized equipment.						
CRITERION 17.4.2.7							
Equipment is upgraded (based on evidence) from time to time so as to keep pace with advancement in operative and	1. Equipment are being replaced and upgraded to meet current standard of care in a planned and systematic manner; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
diagnostic techniques and technology.	2. Procurement of new technology where required is evidenced.						

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STANDARD 17.4.3

FACILITIES FOR REHABILITATION MEDICINE OUTPATIENT SERVICES

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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17.4.3.1							
The Specialist Outpatient Services shall have the following features: a) The organization 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	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; and						
	i. Adequate waiting area, rest rooms, refreshments, reading material and parking space.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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); and n) Sinks with hand washing facilities to be available in all treatment areas							
CRITERION 17.4.3.2							
Adequate numbers of rooms are provided to ensure patient	1. Adequate facilities for consultation and patient care activities that						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and c) Performance of various tests.	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; and						
	d. List of procedures done.						
CRITERION 17.4.3.3 (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care.						

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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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17.5.1.1							
There are periodical planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Rehabilitation Medicine Services. The process includes: d) Planned activities; e) Data collection; f) Monitoring and evaluation of the performance; g) Action plan for improvement; h) Implementation of action plan; i) Re-evaluation for improvement; and j) Innovation.	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; and						
	5. Records on innovation if available.						
CRITERION 17.5.1.2							
The Head of Rehabilitation Medicine Services as assigned the responsibilities for planning, monitoring and managing safety and performance improvement to appropriate individual/personnel within the respective services.	1. Minutes of meetings;						
	2. Letter of assignment of responsibilities; and						
	3. Job description.						
CRITERION 17.5.1.3							
The Head of Rehabilitation Medicine Services shall ensure that	1. System for incident reporting is in place, which include:						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.	a. Training of staff;						
	b. Policy on incident reporting;						
	c. Methodology of incident reporting; and						
	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; and						
	8. Feedback given to staff regarding incident reporting.						
CRITERION 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:	1. Performance improvement activities;						
	2. Minutes of meetings; and						
	3. Relevant reports and documents, e.g. clinical audit reports, incident reports, mortality and morbidity review reports, etc.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
i) As a single committee for all safety and performance improvement activities; ii) In multidisciplinary committees within the Services; and iii) In a variety of purpose-specific committees, such as mortality and morbidity, infection control, blood transfusion, etc. b) Whatever structure is utilized, provision is made for review and analysis of the clinical work of each individual clinical service, department, unit or function; and c) Clinical audit assessment is undertaken at least one (1) annually.							
CRITERION 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 ≤90 minutes to see the doctor at the Rehabilitation Medicine Outpatient Clinic (Only ONE registration involved) (Target : >90%); b) Percentage of patients with established interdisciplinary rehabilitation plan within ≤5	1. Specific performance indicators monitored;						
	2. Records on tracking and trending analysis; and						
	3. Remedial measures taken where appropriate.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
working days of admission. (Target:> 90%); d) Percentage of falls and near-falls in Rehabilitation Medicine Outpatient Clinic. (Target <2%); and e) Percentage of inpatients with functional measure assessment upon admission and prior to cessation of patient rehabilitation programme (Target: >90%).							
CRITERION 17.5.1.6 (NEW)							
The Services participates in the Facility's safety culture assessment. The results are utilized by Service leadership to inform and guide efforts to improve the culture of safety within the Service.	1. Safety Culture Survey for staff						
CRITERION 17.5.1.7							
Feedback on results of safety and performance improvement activities are regularly communicated to the staff to promote transparency, shared learning, and active engagement in improvement initiatives.	1. Results on safety and performance improvement activities are accessible to staff through education sessions, meetings and digital communications.						
CRITERION 17.5.1.8							
Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical	1. Documentation on performance improvement activities and performance indicators; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
practitioners, staff and patients is preserved.	2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						

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TOPIC 17.6
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 17.6.1
SPINAL CORD INJURY
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17.6.1.1							
ORGANISATION OF SPINAL CORD INJURY CARE The provision of Spinal Cord Injury Care shall be organized 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, Orthopedics, Neurosurgery, Obstetrics and Gynecology, Reproductive Medicine, Orthotic service is available or accessible; d) Care plans are individualized, planned, monitored and evaluated; e) Interdisciplinary records (IDR) and family conferences are an integral part of inpatient rehabilitation;	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; and						
	5. Evidence of registry of rehabilitated Spinal Cord Injury (SCI) patients						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
f) Patient assessment, functional and clinical status are measured at admission and upon discharge utilizing 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; and i) A registry of rehabilitated spinal cord injury patients will be maintained.							
CRITERION 17.6.1.2							
STAFFING REQUIREMENTS a) The minimum number of staff for Level 4 Spinal Cord Injury Rehabilitation Service shall be as per rehabilitation standards except for: i) Rehabilitation Physician :1:16 patients; ii) Medical Officers :1:8 patients; iii) Nurses / Medical Assistants :1:4 patients(At least Preferably 1 post	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;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
basic rehabilitation nurse available per shift); iv) Physiotherapist :1:6 patients; v) Occupational Therapists :1:6 patients; vi) Speech Therapists :1:6 patients; vii) Medical Social Worker :1:24 patients; viii) Clinical Psychologist:1:24 patients; ix) Psychology Counsellors:1:24 patients; x) Healthcare Assistants :1:4 patients; and 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; 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; and d) A case manager is preferable for each case.	5. Patient's Clinical notes; and 6. Workload Census.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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) Specialized wheelchairs – recliner, DAF, lightweight, motorized and bariatric ; f) Shower trolley or reclining commode wheelchair; g) Tilt table; h) Parallel bar; and i) Various types of gait aids.	1. Appropriate and adequate facilities and equipment that include (a) and (e)						
CRITERION 17.6.1.4							
PERFORMANCE IMPROVEMENT 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); and b) Measurement of disease specific functional outcome measure at initial contact and prior to rehabilitation discharge	1. Records on performance improvement that include (a) and (b) as evidenced upon inspection of:						
	a. IDR Documentation; and						
	b. Patient's Clinical Notes.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
- Spinal Cord Injury Independence Measure (SCIM).							

STANDARD 17.6.2
STROKE
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17.6.2.1							
ORGANISATION OF STROKE CARE The provision of Stroke Care shall be organized 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;	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; and 5. Evidence of registry of rehabilitated Stroke patients.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
d) Credentialing and privileging processes are established; and e) A registry of rehabilitated stroke patients will shall be maintained.							
CRITERION 17.6.2.2							
STAFFING REQUIREMENTS a) The minimum number of staff for a Level 4 Stroke Rehabilitation Services shall be as per rehabilitation standards; 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; and e) Allied health staff must undergo at least three (3) months of supervised work/training before undertaking unsupervised responsibilities.	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; and						
	6. Workload Census.						
CRITERION 17.6.2.3							
FACILITIES AND EQUIPMENT FOR STROKE REHABILITATION SERVICES There are adequate and appropriate facilities and equipment for	1. Appropriate and adequate facilities and equipment that include but not limited to (a).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
provision of Stroke Rehabilitation 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 and bariatric; iii) Commode chair/wheelchair; iv) Tilt table; v) Parallel bar; vi) Various types of gait aids; and vii) Hoist for safe transfer.							
CRITERION 17.6.2.4							
Performance Improvement 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); and b) Measurement of disease specific functional outcome measure at initial contact and upon rehabilitation discharge – Motor Assessment Scale (MAS).	1. Records on performance improvement that include (a) and (b) as evidenced upon inspection of:						
	a. IDR Documentation; and						
	b. Patient's Clinical Notes.						

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SERVICE SUMMARY	
OVERALL RATING :	-
OVERALL RISK :	-

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SERVICE STANDARD 17A: ALLIED HEALTH PROFESSIONAL SERVICES – PHYSIOTHERAPY SERVICES

PREAMBLE

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. Physiotherapists may direct their intervention to specific populations, e.g. Cardio-respiratory/Cardio-pulmonary, Neurological, and Musculoskeletal Rehabilitation in all age groups.

These services are provided individually, institutionally, or in groups through social support systems.

TOPIC 17A.1
ORGANISATION AND MANAGEMENT

STANDARD 17A.1.1
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.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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	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 are measurable in line with the Facility statements available, endorsed and dated;						
	3. Evidence of planned reviews of the above statements (at least once in 3 years or in the event of any major changes);						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
accordingly and communicated to all staff.	4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc); and						
	5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.						
CRITERION 17A.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) or Hospital Director, 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; and d) Is revised when there is a major change in any of the following: i) Organisation; ii) Functions; iii) Reporting relationships; and iv) Staffing patterns	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the PIC or Hospital Director, 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; and						
	4. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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 the staff; and 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.	1. The Physiotherapy Services are 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; and					
		d. Physiotherapy Standard Operating Procedures (SOP) are made available, accessible and adhered to professional development plan.					
CRITERION 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	1. Minutes are accessible, disseminated and acknowledged by the staff;						
	2. Attendance list of members with adequate representation of the service;						
	3. Frequency of meetings as scheduled; and						
	4. Discussion and resolutions are implemented.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Minutes of Facility-wide management meeting;						
	2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service; and						
	3. Approved budget and resources.						
CRITERION 17A.1.1.6							
The Head of Physiotherapy Services is involved in the appointment and/or assignment of the staff.	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; and						
	5. Duty roster.						
CRITERION 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.	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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	e. Staff training records; and						
	f. Data on performance improvement activities, including performance indicators.						
CRITERION 17A.1.1.8 (CORE)							
The Head of Physiotherapy Services shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	1. Documented and approved BCP for unanticipated situations;						
	2. List of key emergency functions and identified risks, documented in a unit-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment.						
	3. Clear actions and staff responsibilities during disruption;						
	4. Record of drills or tests, with follow-up actions, if conducted; and						
	5. Review of Risk Register						

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TOPIC 17A.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD 17A.2.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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 2016.	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 processes are being followed to allow practice. of specialised procedures; and						
	4. Training and competency records.						
CRITERION 17A.2.1.2							
The authority, responsibilities and accountabilities of the Head of Physiotherapy Services are clearly delineated and documented.	1. Appointment/Assignment letter for Head of Physiotherapy Services; and						
	2. Description of duties and responsibilities.						
CRITERION 17A.2.1.3 (CORE)							
Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the need of the services.	1. Number of staff and qualification should be commensurate with workload; and						
	2. Appropriate skill mix of physiotherapists should be						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Relevant support staff shall work only under the supervision of a qualified physiotherapist.	available to commensurate with the complexity of the services provided;						
	3. Duty roster; and						
	4. Census and statistics.						
CRITERION 17A.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; and 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; and						
	4. The job description is acknowledged by the staff and signed by the Head of Service and dated.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17A.2.1.5 (CORE)							
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	1. Staff personal records include:						
	a. Curriculum Vitae (CV);						
	b. Qualification and experience;						
	c. Annual practicing certificate;						
	d. Training record;						
	e. Competency record and privileging;						
	f. Leave record; and						
	g. Confidentiality agreement.						
CRITERION 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.	1. Policy requiring all new staff to attend a structured orientation programme;						
	2. Records on structured orientation programme;						
	3. Orientation Brief; and						
	4. List of attendance.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Training needs assessment is carried out and gaps identified;						
	2. A staff development plan based on training needs assessment is available;						
	3. The training schedule/calendar is in place; and						
	4. Training module.						
CRITERION 17A.2.1.8 (CORE)							
There are continuing education activities for staff to pursue professional interests and to prepare for current and future changes in practice.	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; and						
	4. Certificate of attendance/degree/post basic training.						
CRITERION 17A.2.1.9 (CORE)							
Staff receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.	1. Performance appraisal for staff is completed upon probationary period and as an annual exercise.						
CRITERION 17A.2.1.10							
In a Facility where education programmes are conducted, the	1. Letter of appointment – Local Preceptor/Clinical Instructor;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Facility shall ensure that there are sufficient skilled trained staff to provide clinical supervision of students.	2. Memorandum of Understanding with training institution;						
	3. Adequate number of clinical instructor to students; and						
	4. Qualification and training records of local preceptor.						

STANDARD 17A.2.2 (NEW)

The physiotherapy services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the physiotherapy staff, ensuring a safe and healthy work environment.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17A.2.2.1 (CORE)							
The physiotherapy services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being.	1. Documented Policies and Procedures Staff Well-Being Policy (covering physical, mental, and spiritual health).; and						
	2. Monitoring and Review Mechanisms Staff wellbeing surveys, feedback reports and actions.						
CRITERION 17A.2.2.2 (CORE)							
The physiotherapy services shall establish a safe mechanism for physiotherapy staff to express grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety.	1. Physiotherapy staff suggestions, grievance reporting processing mechanisms are available;						
	2. The resolution of workplace issues may involve the following:						
	a. Policy and procedures for the protection of the whistleblower;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	b. Anonymous reports received from staff;						
	c. Staff orientation modules to include violence and whistleblower protection, bullying, and harassment;						
	d. Awareness campaigns to promote safe workplace culture; and						
	e. Training and adherence to documented policies and procedures for violence activation and physiotherapy staff protection.						
CRITERION 17A.2.2.3 (NEW)							
A system shall be created to gather physiotherapy staff feedback about their workplace experience such as burnout which shall be analysed and used to make improvements that enhance the work environment, physiotherapy staff satisfaction, and organisation culture.	1. Physiotherapy staff feedback (e.g., minutes of sessions or physiotherapy staff satisfactions survey):						
	a. Evidence of action or improvement taken.						
CRITERION 17A.2.2.4 (NEW)							
The physiotherapy services shall track sick leave and physiotherapy staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning	1. Workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments; and						
	2. The results shall be used to create focused actions that improve						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	physiotherapy staff well-being, solve problems, and help retain physiotherapy employees.						

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TOPIC 17A.3
POLICIES AND PROCEDURES

STANDARD 17A.3.1
DEVELOPMENT, DERIVATION AND DOCUMENTATION
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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, current standard practices and Patients and Family Rights. 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.	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; and						
	4. The policies and procedures are endorsed and dated.						
CRITERION 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;	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;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
b) Pre-treatment risk assessment; c) Prevention and control of infection practices where applicable; d) Monitoring of the patient to assess the outcome of the care of patient; e) Modifying the care when necessary; f) Completing the care; g) Discharge care plan and follow up; h) Cross-referral within team; i) Referral guidelines; j) Communication – within and outside the physiotherapy services; and k) Risk registry Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.	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; and						
	f. Original referral forms.						
	7. Care plan and discharge plan including educational material provided for the patient.						
CRITERION 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.	1. Policy for Code Blue is available within the service area; and						
	2. Flow chart and contact number of Code Blue made available and accessible.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17A.3.1.4							
Current policies and procedures are communicated to all staff.	3. Training and briefing on the current policies and procedures/Minutes of meetings; and						
	4. Circulation list and acknowledgement.						
CRITERION 17A.3.1.5 (CORE)							
There is evidence of implementation and compliance with relevant policies and procedures through Risk Assessments prior to treatment.	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						
CRITERION 17A.3.1.6							
All outpatients seeking consultation or treatment with the Physiotherapy Services shall receive an initial referral from a medical practitioner to an Allied Health Professional (AHP). Subsequent referrals or follow-up consultations may be initiated by the AHP, as appropriate.	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; and						
	4. Patient's medical record						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17A.3.1.7							
Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By Laws and statutory requirements are accessible for staff reference.	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.						

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TOPIC 17A.4
FACILITIES AND EQUIPMENT

STANDARD 17A.4.1
Safe and adequate facilities and equipment are available for the delivery of effective physiotherapy services and ensuring patient safety.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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;						
	4. Easy access and clear exit routes; and						
	5. Absence of overcrowding.						
CRITERION 17A.4.1.2							
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); and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	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 (if applicable)						
CRITERION 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.	1. Planned Preventive Maintenance records such as schedule, stickers, etc;						
	2. Planned Replacement Programme where applicable;						
	3. Complaint records; and						
	4. Asset inventory.						
CRITERION 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 (if applicable)	1. User training records;						
	2. Competency record;						
	3. Letter of authorisation; and						
	4. List of staff trained and privileged to operate specialised equipment.						
CRITERION 17A.4.1.5 (CORE)							
Disabled friendly toilets with call systems for assistance shall be made available.	1. Disabled friendly toilet with alarm bell/call system is available.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17A.4.1.6							
Alarm system for emergencies appropriate to client needs shall be made available	1. Emergency alert alarm system, i.e. mechanical and Code Blue is in place.						
CRITERION 17A.4.1.7							
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; and 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.	1. Design of the physical rehabilitation activity facilities meets the standard requirements and includes the aspects of (a) to (d); and 2. Presence of the required equipment for the relevant rehabilitation activities.						
CRITERION 17A.4.1.8							

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Where Artificial Intelligence (AI) Technology is incorporated into medical equipment or clinical practice, there is evidence that only staff who are trained and privileged by the Facility to operate such technology.	1. User training records;						
	2. Competency assessment record;						
	3. Letter of privileging; and						
	4. List of staff trained and privileged to operate specialised equipment						
CRITERION 17A.4.1.9 (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care.						

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TOPIC 17A.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 17A.5.1
The Head of Physiotherapy Services shall foster high quality performance by involving staff in safety and continuous improvement initiatives, including systematic risk management, active physiotherapy staff involvement and the use of performance data to drive service enhancements. A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17A.5.1.1							
There are periodical 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; and g) Innovation.	1. Planned performance improvement activities include (a) to (g);						
	2. Records on performance improvement activities;						
	3. Minutes of performance improvement meetings;						
	4. Performance improvement studies; and						
	5. Records on innovation if available.						
CRITERION 17A.5.1.2							
The Head of Physiotherapy Services as assigned the responsibilities for planning, monitoring and managing safety and performance improvement to	1. Minutes of meetings;						
	2. Letter of assignment of responsibilities; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
appropriate individual/personnel within the respective services.	3. Job description.						
CRITERION 17A.5.1.3							
The Head of Physiotherapy Services shall ensure that staff are trained and that they complete incident reports. These reports shall be promptly reported, investigated, and discussed by the staff with learning objectives, before being submitted to the PIC of the Facility. Where appropriate, according to the Facility matrix, reported incidents undergo an RCA and corrective and preventive action is taken within the agreed time frame to prevent recurrence.	1. A system for incident reporting is in place and includes the following:						
	a. Training of staff;						
	b. Policy on incident reporting; and						
	c. Register/Records of incidents.						
	2. Completed incident reports.						
	a. RCA;						
	b. Corrective and preventive action plans; and						
	c. Remedial measure.						
	3. Clinical audit including patient safety reviews (e.g., mortality and morbidity review, etc);						
	4. Sentinel Event Investigations with appropriate corrective and preventive actions (CAPA), and oversight by the governing body;						
	5. Grievance Mechanism, both staff and public, including grievance reporting and processing mechanisms are available;						
	6. Minutes of meetings;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	7. Acknowledgment by Head of Service and PIC; and						
	8. Feedback and learnings from incident reporting are shared with staff.						
CRITERION 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: 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 three (3) sessions) within two (2) months (Target: 80%); c) Percentage of inpatient referrals seen on time (≤24 hours) by the physiotherapist. (Target: 90%); d) Rate of positive outcomes from cases referred for chest physiotherapy by Intensive Care Unit; and e) Improvement in Modified Rivermead Mobility Index (MRMI) score within six (6) months of physiotherapy intervention for newly referred stroke patient.	1. Specific performance indicators monitored, verified, and validated;						
	2. Records on tracking and trending analysis;						
	3. Remedial measures taken where appropriate;						
	4. Review any performance indicator over a one-year period that:						
	a. Have consistently met or exceeded targets; and						
	b. Continue to show persistent SIQ or performance.						
	5. Where applicable, review the target or identify new indicators.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17A.5.1.5							
The Services participates in the Facility's safety culture assessment. The results are utilised by Service leadership to inform and guide efforts to improve the culture of safety within the Service.	1. Safety Culture Survey for staff						
CRITERION 17A.5.1.6							
Feedback on the results of safety and performance improvement activities is regularly communicated to the staff to promote transparency, shared learning, and active engagement in improvement initiatives.	1. Results on safety and performance improvement activities are accessible to staff through education sessions, meetings and digital communications.						
CRITERION 17A.5.1.7							
Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.	1. Documentation on performance improvement activities and performance indicators; and						
	2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						

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SERVICE SUMMARY	
OVERALL RATING :	-
OVERALL RISK :	-

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GLOSSARY

Business Continuity Plan (BCP)
A written plan that outlines how the unit will continue its most important services when normal operations are disrupted (e.g., due to power failure, flood, or IT outage).

Workaround Strategies
Temporary actions taken when normal resources or systems are unavailable. For example: using manual paper-based records, or shifting care to alternate site

Test/Drill/Simulation
A planned activity where staff practice what to do during a service disruption (e.g., mock code orange, system downtime drill). Helps improve readiness

Follow-up Actions
Improvements or changes made after a drill or real incident, based on what worked and what didn't. This ensures the plan gets better over time.

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SERVICE STANDARD 17B : ALLIED HEALTH PROFESSIONAL SERVICES – OCCUPATIONAL THERAPY SERVICES

PREAMBLE

Occupational therapy is a client-centred health profession concerned with promoting health and wellbeing through occupational interventions. The primary goal is to enable people to participate in activities of everyday life. Occupational therapists achieve 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. (World Federation of Occupational Therapists, WFOT 2012)
These services are provided individually, institutionally, or in groups through social support systems.

TOPIC 17B.1
ORGANISATION AND MANAGEMENT

STANDARD 17B.1.1

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.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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 are measurable in line with the Facility statements available, endorsed and dated;						
	3. Evidence of planned reviews of the above statements (at least once in 3 years or in the event of any major changes;						
	4. These statements are communicated to all staff						

DISTRIBUTION

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	(orientation programme, minutes of meeting, etc.); and						
	5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.						
CRITERION 17B.1.1.2 (CORE)							
There is an organisation chart which: a) Provides a clear representation of the structure, function and reporting relationships between thel Person In Charge (PIC) or Hospital Director, consultants, medical practitioners, Head of Physiotherapy Services and staff of the Physiotherapy Services;reflect the link to relevant medical subspecialties services/units; b) Is accessible to all staff and clients; c) Includes off-site services if applicable; and d) Is revised when there is a major change in any of the following: a. Organisation; b. Functions; c. Reporting relationships; and d. Staffing patterns.	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;						
	2. The 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; and						
	4. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17B.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 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; assure continuity of care; b) Assure continuity of care; c) Address the professional needs of the staff; and 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.	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;					
		d. Occupational Therapy Standard Operating Procedures (SOP) and Code of Ethics made available, accessible and adhered to; and					
		e. Professional Development Plan.					
CRITERION 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.	1. Minutes are accessible, disseminated and acknowledged by the staff;						
	2. Attendance list of members with adequate representation of service;						
	3. Frequency of meetings as scheduled; and						
	4. Discussion and resolutions are implemented.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Minutes of Facility-wide management meeting;						
	2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service; and						
	3. Approved budget and resources.						
CRITERION 17B.1.1.6							
The Head of Physiotherapy Services is involved in the appointment and/or assignment of the staff.	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; and						
	5. Duty roster.						
CRITERION 17B.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.	1. Records are available but not limited to the following:						
	a. Workload/Census;						
	b. Annual report;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	c. Accident/Incident reports;						
	d. Staffing number and staff profile;						
	e. Staff training records; and						
	f. Data on performance improvement activities, including performance indicators.						
CRITERION 17B.1.1.8							
The Head of Services shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	1. Documented and approved BCP for unanticipated situations;						
	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment.						
	3. Clear actions and staff responsibilities during disruption;						
	4. Record of drills or tests, with follow-up actions, if conducted; and						
	5. Review of Risk Register.						

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TOPIC 17B.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD 17B.2.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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 letter;						
	3. Certification; and						
	4. Training and competency records including privileging.						
CRITERION 17B.2.1.2							
The authority, responsibilities and accountabilities of the Head of Occupational Therapy Services are clearly delineated and documented.	1. Appointment/assignment letter for Head of Service; and						
	2. Description of duties and responsibilities.						
CRITERION 17B.2.1.3 (CORE)							
Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the need of the services.	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;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Relevant support staff shall work only under the supervision of a qualified occupational therapist.	3. Work Schedule; and						
	4. Census and statistics.						
CRITERION 17B.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; and 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; and						
	4. The job description is acknowledged by the staff and signed by the Head of Service and dated.						
CRITERION 17B.2.1.5							
Personnel records on training, staff development, leave and others are maintained for every staff.	1. Staff personal records include:						
	a. Curricular Vitae (CV)						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Note: Staff personal record may be kept in Human Resource Department as per Facility policy	b. Qualification and experience;						
	c. Annual practicing certificate						
	d. Training record;						
	e. Competency record and privileging;						
	f. Leave record; and						
	g. Confidentiality agreement.						
CRITERION 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.	1. Policy requiring all new staff to attend a structured orientation programme;						
	2. Records on structured orientation programme;						
	3. Orientation Brief; and						
	4. List of attendance.						
CRITERION 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.	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; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	4. Training module.						
CRITERION 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.	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; and						
	4. Certificate of attendance/degree/post basic training.						
CRITERION 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.	1. Performance appraisal for staff is completed upon probationary period and as an annual exercise.						
CRITERION 17B.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.	1. Letter of appointment – Local Preceptor/Clinical Instructor;						
	2. Memorandum of Understanding with training institution;						
	3. Adequate number of clinical instructors to students; and						
	4. Qualification and training records of local preceptor.						

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STANDARD 17B.2.2 (NEW)

The occupational therapy services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the occupational therapy staff, ensuring a safe and healthy work environment.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17B.2.2.1 (CORE) (NEW)							
The occupational therapy services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being.	1. Documented Policies and Procedures Staff Well-Being Policy (covering physical, mental, and spiritual health); and						
	2. Monitoring and Review Mechanisms Staff wellbeing surveys, feedback reports and actions.						
CRITERION 17B.2.2.2 (CORE) (NEW)							
The occupational therapy services shall establish a safe mechanism for occupational therapy staff to express grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety.	1. Occupational therapy staff suggestions, grievance reporting and processing mechanisms are available;						
	2. The resolution of workplace issues may involve the following:						
		a. Policy and procedures for the protection of the whistleblower;					
		b. Anonymous reports received from staff;					
		c. Staff orientation modules to include violence and whistleblower protection, bullying, and harassment; and					
		d. Awareness campaigns to promote safe workplace culture; and					

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	e. Training and adherence to documented policies and procedures for violence activation and physiotherapy staff protection.						
CRITERION 17B.2.2.3 (NEW)							
A system shall be created to gather staff feedback about their workplace experience such as burnout which shall be analysed and used to make improvements that enhance the work environment, staff satisfaction, and organisation culture.	1. Staff feedback (e.g., minutes of sessions or staff satisfactions survey):						
	a. Evidence of action or improvement taken.						
CRITERION 17B.2.2.4 (NEW)							
The occupational therapy services shall track sick leave and occupational therapy staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning	1. Workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments; and						
	2. The results shall be used to create focused actions that improve physiotherapy staff well-being, solve problems, and help retain physiotherapy employees.						

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TOPIC 17B.3
POLICIES AND PROCEDURES

STANDARD 17B.3.1
DEVELOPMENT, DERIVATION AND DOCUMENTATION
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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, current standard practices and Patients and Family Rights. 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.	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; and						
	4. The policies and procedures are endorsed and dated.						
CRITERION 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:	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;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
a) Care plan for each patient to achieve appropriate outcomes; b) Pre-treatment risk assessment; c) Prevention and control of infection practices where applicable; d) Monitoring of the patient to assess the outcome of the care of patient; e) Modifying the care when necessary; f) Completing the care; g) Discharge care plan and follow up; h) Ross-referral within team; i) Referral guidelines; j) Communication – within and outside the physiotherapy services; and k) Risk registry. Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.	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 covers 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; and						
	f. Original referral forms.						
	7. Care plan and discharge plan including educational material provided for the patient.						
CRITERION 17B.3.1.3							
There shall be a policy to address emergency resuscitation in the	1. Policy for Code Blue is available within the service area; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
event of any life-threatening situations and the Emergency Resuscitation Team can be alerted immediately, e.g. Code Blue.	2. Flow chart and contact number of Code Blue made available and accessible.						
CRITERION 17B.3.1.4							
Current policies and procedures are communicated to all staff.	1. Training and briefing on the current policies and procedures/Minutes of meetings; and						
	2. Circulation list and acknowledgement.						
CRITERION 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.	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; and						
	e. Practices in line with established policies and procedures.						
CRITERION 17B.3.1.6							
All outpatients seeking consultation or treatment with the Speech-Language Therapy Services shall receive an initial referral from a medical practitioner to an Allied Health Professional	1. Facility policy on referral to allied health services by medical practitioner;						
	2. Referral letter/referral form written by medical practitioner;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
(AHP). Subsequent referrals or follow-up consultations may be initiated by the AHP, as appropriate.	3. All patients/clients are registered in the manual register book or electronic system; and						
	4. Patient's medical record.						
CRITERION 17B.3.1.7							
Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.	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); and						
	d. Occupational Therapy Code of Ethics and Professional Conduct.						

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TOPIC 17B.4
FACILITIES AND EQUIPMENT

STANDARD 17B.4.1
Safe and adequate facilities and equipment are available for the delivery of effective Occupational Therapy Services and ensuring patient safety.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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;						
	4. Easy access and clear exit routes; and						
	5. Absence of overcrowding.						
CRITERION 17B.4.1.2							
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); and						
	2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), Medical Device Authority (MDA), Malaysian Certification (MC) etc as evidence of compliance to the relevant standards and Acts.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Planned Preventive Maintenance records such as schedule, stickers, etc;						
	2. Planned Replacement Programme where applicable;						
	3. Complaint records; and						
	4. Asset inventory.						
CRITERION 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.	1. User training records;						
	2. Competency record;						
	3. Letter of authorization; and						
	4. List of staff trained and privileged to operate specialised equipment.						
CRITERION 17B.4.1.5 (CORE)							
Disabled friendly toilets with call systems for assistance shall be made available.	1. Disabled friendly toilet with alarm bell/call system is available.						
CRITERION 17B.4.1.6							
Alarm system for emergencies appropriate to client needs shall be made available	1. Emergency alert alarm system, i.e. mechanical and Code Blue is in place.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17B.4.1.7							
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.	1. Presence of the required facilities and equipment for occupational therapy activities.						
CRITERION 17B.4.1.8 (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care.						

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TOPIC 17B.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 17B.5.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17B.5.1.1							
There are periodical 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; and g) Innovation	1. Planned performance improvement activities include (a) to (g);						
	2. Records on performance improvement activities;						
	3. Minutes of performance improvement meetings;						
	4. Performance improvement studies; and						
	5. Records on innovation if available.						
CRITERION 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.	1. Minutes of Meetings.						
	2. Letter of assignment of responsibilities.						
	3. Job description.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17B.5.1.3 (CORE)							
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.	1. System for incident reporting is in place, which include:						
	a. Training of staff;						
	b. Policy on incident reporting;						
	c. Methodology of incident reporting; and						
	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; and						
	8. Feedback given to staff regarding incident reporting.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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 in Activities of Daily Living (ADL) independence after 6 3 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%); and 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%)	1. Specific performance indicators monitored; 2. Records on tracking and trending analysis; and 3. Remedial measures taken where appropriate.						
CRITERION 17B.5.1.5 (NEW)							
The Services participates in the Facility's safety culture assessment. The results are utilized by Service leadership to inform and guide efforts to improve the culture of safety within the Service.	1. Safety Culture Survey for staff.						
CRITERION 17B.5.1.6							
Feedback on the results of safety and performance improvement activities are regularly communicated to the staff to	1. Results on safety and performance improvement activities are accessible to staff through						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
promote transparency, shared learning, and active engagement in improvement initiatives.	education sessions, meetings and digital communications.						
CRITERION 17B.5.1.7							
Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.	1. Documentation on performance improvement activities and performance indicators; and						
	2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						

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SERVICE SUMMARY	
OVERALL RATING :	-
OVERALL RISK :	-

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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 and shall encompass the following:

a) Individualised patients' nutritional needs as prescribed.

b) Documented Nutrition Care Process:

- ***1) Nutrition assessment***
- ***2) Nutrition diagnosis***
- ***3) Nutrition intervention***
- ***4) Nutrition monitoring and evaluation***

c) Standards of professional performance:

- ***1) Provision of services – provides evidence based, safe and quality service to the patients.***
- ***2) Communication and application of knowledge – effectively applies knowledge and communicates with others involved in the care of the patient.***
- ***3) Application of research – effectively applies, participates in or generates research to enhance practice.***
- ***4) Utilisation and management of resources – uses resources effectively and efficiently in practice.***
- ***5) 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.***
- ***6) Continued competence and professional accountability – engages in lifelong self-development to improve knowledge and enhance professional competency***

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TOPIC 17C.1
ORGANISATION AND MANAGEMENT

STANDARD 17C.1.1
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.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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 are measurable in line with the Facility statements available, endorsed and dated;						
	3. Evidence of planned reviews of the above statements (at least once in 3 years or in the event of any major changes);						
	4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc); and						
	5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.						
CRITERION 17C.1.1.2 (CORE)							
There is an organisation chart which:	1. Clearly delineated current organisation chart with line of functions and reporting						

DISTRIBUTION

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
a) Provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head of Dietetic Services and staff of Dietetic Services; b) Is accessible to all staff and clients; c) Includes off-site services if applicable; and d) Is revised when there is a major change in any of the following: i) Organisation; ii) Functions; iii) Reporting relationships; and iv) Staffing patterns.	relationships between the Person In Charge (PIC), Head of Dietetic Services and staff of the Dietetic Services; 2. Organisation chart of the service is endorsed, dated and accessible; and 3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).						
CRITERION 17C.1.1.3 (CORE)							
The dietitian who is the Head of the service shall be responsible for the Dietetic Services.	1. Appointment letter of Head of Service; 2. Job description of the Head of Dietetic Services; and 3. Monitoring reports on the service.						
CRITERION 17C.1.1.4							
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,	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;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and 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.	b. Number of dietitians commensurate with workload to provide the necessary service;						
	c. Dietetic care note in the patient's medical record;						
	d. Staff training records;						
	e. Minutes of meeting; and						
	f. Operational policies and procedure.						
CRITERION 17C.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 Dietetic 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 representation of the service;						
	3. Frequency of meetings as scheduled; and						
	4. Discussion and resolutions are implemented.						
CRITERION 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.	1. Minutes of Facility-wide management meeting;						
	2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	3. Approved budget and resources.						
CRITERION 17C.1.1.7							
The Head of Dietetic Services is involved in the appointment and/OR assignment of the staff.	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; and						
	5. Duty Roster.						
CRITERION 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.	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; and						
	f. Data on performance improvement activities, including performance indicators.						
CRITERION 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	1. Terms of Agreement include all items (a) to (f); and						
	2. Compliance with the terms of the agreement evidenced on site;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and f) Space, facilities and equipment are provided by the organisation							
CRITERION 17C.1.1.10							
The Head of Services shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	1. Documented and approved BCP for unanticipated situations;						
	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment.						
	3. Clear actions and staff responsibilities during disruption;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	4. Record of drills or tests, with follow-up actions, if conducted; and						
	5. Review of Risk Register.						

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TOPIC 17C.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD 17C.2.1
The Dietetic Services shall be directed and adequately staffed by qualified 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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17C.2.1.1 (CORE)							
The Head and staff of the Dietetic Services shall be individuals qualified by education, training 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.	1. Annual Practicing Certificate (APC);						
	2. 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;						
	3. Appointment/assignment letters; and						
	4. Training and competency records.						
CRITERION 17C.2.1.2							
The authority, responsibilities and accountabilities of the Head of Dietetic Services are clearly delineated and documented.	1. Appointment letter for Head of Service; and						
	2. Job description.						
CRITERION 17C.2.1.3 (CORE)							
Sufficient numbers of dietitians 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 dietitians.	1. Number of dietitians commensurate with workload to provide the necessary service;						
	2. Number of staff and qualification should commensurate with workload;						
	3. Duty roster; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	4. Census and statistics						
CRITERION 17C.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; and 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; and						
	4. The job description is acknowledged by the staff and signed by the Head of Service and dated.						
CRITERION 17C.2.1.5							
Personnel records on training, staff development, leave and others are maintained for every staff. **Note:**	1. Staff personal records include:						
	a. Curricular Vitae (CV)						
	b. Qualification and experience;						
	c. Annual practicing certificate;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Staff personal record may be kept in Human Resource Department as per Facility policy	d. Training record;						
	e. Competency record and/or credentialing and privileging;						
	f. Leave record; and						
	g. Confidentiality agreement.						
CRITERION 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.	1. Policy requiring all new staff to attend a structured orientation programme;						
	2. Records on structured orientation programme;						
	3. Training module; and						
	4. List of attendance.						
CRITERION 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.	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; and						
	4. Training module.						
CRITERION 17C.2.1.8							
There are continuing education activities for staff to pursue	1. Continuing education activities and schedule						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
professional interests and to prepare for current and future changes in practice.	2. Contents of training programme and records in specialised dietetic care, e.g. cardiac, renal, diabetes, paediatrics, intensive care, burns, cancer, nutrition support; and						
	3. Training records on continuing education activities are kept and maintained for each staff.						
CRITERION 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.	1. Performance appraisal for staff is completed upon probationary period and as an annual exercise.						
CRITERION 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.	1. Letter of appointment – Local Preceptor/Clinical Instructor;						
	2. Memorandum of Understanding with training institution;						
	3. Adequate number of clinical instructors to students - Dietitian: Student ratio (1:6); and						
	4. Qualification and training records of local preceptor.						

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STANDARD 17C.2.2 (NEW)

The dietetic services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the dietetics staff, ensuring a safe and healthy work environment.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17C.2.2.1 (CORE) (NEW)							
The dietetic services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being.	1. Documented Policies and Procedures Staff Well-Being Policy (covering physical, mental, and spiritual health); and						
	2. Monitoring and Review Mechanisms Staff wellbeing surveys, feedback reports and actions.						
CRITERION 17C.2.2.2 (CORE) (NEW)							
The dietetic services shall establish a safe mechanism for dietetic staff to express grievance, provide suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety	1. Dietetic staff suggestions, grievance reporting and processing mechanisms are available;						
	2. The resolution of workplace issues may involve the following:						
	a. Policy and procedures for the protection of the whistleblower;						
	b. Anonymous reports received from staff;						
	c. Staff orientation modules to include violence and whistleblower protection, bullying, and harassment;						
	d. Awareness campaigns to promote safe workplace culture; and						
	e. Training and adherence to documented policies and procedures for violence activation and dietetic staff protection.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17C.2.2.3 (NEW)							
A system shall be created to gather staff feedback about their workplace experience such as burnout which shall be analysed and used to make improvements that enhance the work environment, staff satisfaction, and organisation culture.	1. Staff feedback (e.g., minutes of sessions or staff satisfactions survey):						
	a. Evidence of action or improvement taken.						
CRITERION 17C.2.2.4 (NEW)							
The dietetic services shall track sick leave and dietetic staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning	1. Workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments; and						
	2. The results shall be used to create focused actions that improve staff well-being, solve problems, and help retain employees.						

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TOPIC 17C.3
POLICIES AND PROCEDURES

STANDARD 17C.3.1
DEVELOPMENT, DERIVATION AND DOCUMENTATION
There are written and dated policies and procedures for all activities of the Dietetic Services. These policies and procedures reflect current standards of Dietetic services and practice, relevant regulations, statutory requirements, and the goals and objectives of the Dietetic Services.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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, current standard practices and Patients and Family Rights. 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.	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.						
CRITERION 17C.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	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.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
involved. Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.	3. Documented cross departmental policies.						
CRITERION 17C.3.1.3							
The dietary requirements of a patient shall be documented in a nutrition care process which includes nutrition assessment, nutrition diagnosis, nutrition intervention, nutrition monitoring and evaluation in consultation with the medical practitioners and communicated to the nurses.	1. Dietetic care notes in patient's medical records.						
CRITERION 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.	1. Policy for Code Blue is available within the service area; and						
	2. Flow chart and contact number of Code Blue made available and accessible.						
CRITERION 17C.3.1.5							
Current policies and procedures are communicated to all staff.	1. Training and briefing on the current policies and procedures/Minutes of meetings; and						
	2. Circulation list and acknowledgement.						
CRITERION 17C.3.1.6 (CORE)							
There is evidence of compliance with policies and procedures and standards of practice.	1. Compliance with policies and procedures through:						
	a. Interview of staff on practices;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	b. Verify with observation on practices;						
	c. Results of audit on practices; and						
	d. Practices in line with established policies and procedures.						
CRITERION 17C.3.1.7							
All outpatients seeking consultation or treatment with the Dietetic Services shall receive an initial referral from a medical practitioner to an Allied Health Professional (AHP). Subsequent referrals or follow-up consultations may be initiated by the AHP, as appropriate.	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; and						
	4. Patient's medical records.						
CRITERION 17C.3.1.8							
Prescription of therapeutic diets, and enteral feeding shall be performed by the dietitian in consultation with the referring medical practitioner.	1. Referral letter from referring medical practitioner; and						
	2. Patient's medical records.						
CRITERION 17C.3.1.9							
A current diet manual is available to Dietitian, 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	3. Current Hospital diet manual.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
therapeutic diets and those to suit religious and cultural preferences.							
CRITERION 17C.3.1.10							
Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site/workstation for staff reference; and						
	2. Clinical Practice Guidelines.						

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TOPIC 17C.4
FACILITIES AND EQUIPMENT

STANDARD 17C.4.1
Appropriate facilities and equipment shall be available for the efficient operation of the Dietetic Services.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Adequate and proper utilisation of space;						
	2. Appropriate type of equipment to match the complexity of services- Assessment tools and education tools; and						
	3. Easy access and clear exit routes.						
CRITERION 17C.4.1.2							
There shall be a room to ensure privacy and easily accessible to provide dietary consultation to the patients.	1. Dietitian consultation room.						
CRITERION 17C.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); and						
	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.						
CRITERION 17C.4.1.4							
Where specialised equipment is used, there is evidence that only	1. User training records;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
staff who are trained and authorised by the Facility operate such equipment.	2. Competency record;						
	3. Letter of authorisation; and						
	4. List of staff trained and privileged to operate specialised equipment.						
CRITERION 17C.4.1.5 (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care.						

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TOPIC 17C.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 17C.5.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17C.5.1.1							
There are periodical 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; and g) Innovation.	1. Planned performance improvement activities include (a) to (g);						
	2. Records on performance improvement activities;						
	3. Minutes of performance improvement meetings;						
	4. Performance improvement studies; and						
	5. Records on innovation if available.						
CRITERION 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.	1. Minutes of meetings; and						
	2. Job description/ Letter of assignment of responsibilities.						
CRITERION 17C.5.1.3							
The Head of the Dietetic Services shall ensure that the staff are trained and complete incident reports which are promptly	1. System for incident reporting is in place, which include:						
	a. Training of staff;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.	b. Policy on incident reporting;						
	c. Methodology of incident reporting; and						
	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; and						
	8. Feedback given to staff regarding incident reporting.						
CRITERION 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: a) Percentage of Inpatients Assessed for Malnutrition Risk Through Nutritional Screeing within 24 Hours of Referral Being Received by the Dietitian. (Target: ≥70%); b) Percentage of outpatients referrals seen by the dietitian within the stipulated time by the Dietetic Services and	1. Specific performance indicators monitored;						
	2. Records on tracking and trending analysis; and						
	3. Remedial measures taken where appropriate.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
approved by the Facility. (Target: ≥85-95%); and c) Percentage of High Risk Mulnutrition Patients Receiving Nutritional Follow-up Care. (Target: ≥70%).							
CRITERION 17C.5.1.5 (NEW)							
The Services participates in the Facility's safety culture assessment. The results are utilized by Service leadership to inform and guide efforts to improve the culture of safety within the Service.	1. Safety Culture Survey for staff						
CRITERION 17C.5.1.6							
Feedback on the results of safety and performance improvement activities are regularly communicated to the staff to promote transparency, shared learning, and active engagement in improvement initiatives.	1. Results on safety and performance improvement activities are accessible to staff through education sessions, meetings and digital communications.						
CRITERION 17C.5.1.7							
Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.	1. Documentations on performance improvement activities and performance indicators; and						
	2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						

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SERVICE SUMMARY	
OVERALL RATING :	-
OVERALL RISK :	-

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SERVICE STANDARD 17D: ALLIED HEALTH PROFESSIONAL SERVICES – SPEECH – LANGUAGE THERAPY SERVICES

PREAMBLE

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 takes 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.

The practice encompasses clinical services of screening, assessment/evaluation, diagnosis, treatment, intervention, consultation, prevention, education, collaboration, documentation and referral to the relevant services.
These services are provided individually, institutionally, or in groups through social support systems.

TOPIC 17D.1
ORGANISATION AND MANAGEMENT

STANDARD 17D.1.1
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.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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	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 are measurable in line with the Facility statements available, endorsed and dated;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.	3. These statements are communicated to all staff (orientation programme, minutes of meeting, etc); and						
	4. Achievement of goals and objectives are monitored, reviewed and revised accordingly.						
CRITERION 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; and d) Is revised when there is a major change in any of the following: i) Organisation; ii) Functions; iii) Reporting relationships; and iv) Staffing patterns.	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; and						
	3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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; and 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.	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 service;					
		c. Privileging for extended clinical role, if any;					
		d. Record on continuity of care in patient's medical treatment record; and					
		e. Professional development plan.					
CRITERION 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	1. Minutes are accessible, disseminated and acknowledged by the staff;						
	2. Attendance list of members with adequate representation of the service;						
	3. Frequency of meetings as scheduled; and						
	4. Discussion and resolutions are implemented.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
staff of the service and implemented.							
CRITERION 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.	1. Minutes of Facility-wide management meeting (if applicable);						
	2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service; and						
	3. Approved budget and resources.						
CRITERION 17D.1.1.6							
The Head of Speech-Language Therapy Services is involved in the appointment and/OR assignment of the staff.	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 (if applicable); and						
	5. Duty roster.						
CRITERION 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.	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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	e. Staff training records; and						
	f. Data on performance improvement activities, including performance indicators (i.e. Clinical audit, /research, /innovation etc).						
CRITERION 17D.1.1.8 (NEW)							
The Head of Services shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	1. Documented and approved BCP for unanticipated situations;						
	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment.						
	3. Clear actions and staff responsibilities during disruption;						
	4. Record of drills or tests, with follow-up actions, if conducted; and						
	5. Review of Risk Register.						

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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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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; and						
	4. Training and competency records including privileging						
CRITERION 17D.2.1.2							
The authority, responsibilities and accountabilities of the Head of Speech-Language Therapy Services are clearly delineated and documented.	1. Appointment/assignment letter for Head of Service; and						
	2. Description of duties and responsibilities.						
CRITERION 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.	1. Number of staff and qualification should commensurate with workload;						
	2. Current Practising Certificate;						
	3. Duty roster; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	4. Census and statistics.						
CRITERION 17D.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; and 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; and						
	4. The job description is acknowledged by the staff and signed by the Head of Service and dated.						
CRITERION 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	1. Staff personal records include:						
	a. Curricular Vitae (CV);						
	b. Qualification and experience;						
	c. Training record;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	d. Competency record and/or credentialing and privileging;						
	e. Leave record; and						
	f. Confidentiality agreement.						
CRITERION 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.	1. Policy requiring all new staff to attend a structured orientation programme;						
	2. Records on structured orientation programme;						
	3. Orientation Brief; and						
	4. List of attendance.						
CRITERION 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.	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; and						
	4. Training module.						
CRITERION 17D.2.1.8							
There are continuing education activities for staff to pursue professional interests and to	1. Continuing education activities and schedule;						
	2. Training module if applicable;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
prepare for current and future changes in practice.	3. Training records on continuing education activities are kept and maintained for each staff; and						
	4. Certificate of attendance/degree/post basic training.						
CRITERION 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.	1. Performance appraisal for staff is completed upon probationary period and as an annual exercise.						
CRITERION 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	1. Letter of appointment – Local Preceptor/ Clinical Instructor;						
	2. Memorandum of Understanding with training institution;						
	3. Adequate number of clinical instructor to students; and						
	4. Qualification and training records of local preceptor.						

STANDARD 17D.2.2 (NEW)

The speech language therapy services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the speech language therapy staff, ensuring a safe and healthy work environment.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17D.2.2.1 (CORE)							
The speech language therapy services shall have policies and procedures for the promotion of	1. Documented Policies and Procedures Staff Well-Being Policy (covering physical, mental, and spiritual health); and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
staff physical, mental and spiritual well-being.	2. Monitoring and Review Mechanisms Staff wellbeing surveys, feedback reports and actions.						
CRITERION 17D.2.2.2 (CORE)							
The speech language therapy services shall establish a safe mechanism for speech language therapy staff to express grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety.	1. Speech language therapy staff suggestions, grievance reporting and processing mechanisms are available;						
	2. The resolution of workplace issues may involve the following:						
	a. Policy and procedures for the protection of the whistleblower;						
	b. Anonymous reports received from staff;						
	c. Staff orientation modules to include violence and whistleblower protection, bullying, and harassment;						
	d. Awareness campaigns to promote safe workplace culture; and						
	e. Training and adherence to documented policies and procedures for violence activation and physiotherapy staff protection.						
CRITERION 17D.2.2.3 (NEW)							
A system shall be created to gather speech language therapy staff feedback about their workplace experience such as burnout which shall be analysed and used to make improvements that enhance the work environment, speech language	1. Speech language therapy staff feedback (e.g., minutes of sessions or speech language therapy staff satisfactions survey):						
	a. Evidence of action or improvement taken.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
therapy staff satisfaction, and organisation culture.							
CRITERION 17D.2.2.4 (NEW)							
The speech language therapy services shall track sick leave and speech language therapy staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning	1. Workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments; and						
	2. The results shall be used to create focused actions that improve speech language therapy staff well-being, solve problems, and help retain speech language therapy employees.						

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TOPIC 17D.3
POLICIES AND PROCEDURES

STANDARD 17D.3.1
DEVELOPMENT, DERIVATION AND DOCUMENTATION
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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, current standard practices and Patients and Family Rights. 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.	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; and						
	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; and						
	4. The policies and procedures are endorsed and dated.						
CRITERION 17D.3.1.2 (CORE)							
Policies and procedures are developed in collaboration with staff and where appropriate with other external services which include:	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;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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 the team; g) Referral guidelines; and h) Communication – within and outside the Speech-Language Therapy Services. Cross-departmental collaboration is practiced in developing relevant policies and procedures where applicable.	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; and						
	f. Original referral forms.						
	6. Care plan and discharge plan.						
CRITERION 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.	1. Policy for Code Blue within the service area; and						
	2. Flow chart and contact number of Code Blue made available and accessible.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17D.3.1.4							
Current policies and procedures are communicated to all staff.	1. Training and briefing on the current policies and procedures/Minutes of meetings; and						
	2. Circulation list and acknowledgement.						
CRITERION 17D.3.1.5							
There is evidence on compliance with policies and procedures.	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; and						
	e. Compliance records and /or compliance audit reports.						
CRITERION 17D.3.1.6							
All outpatients seeking consultation or treatment with the Speech-Language Therapy Services shall receive an initial referral from a medical practitioner to an Allied Health Professional (AHP). Subsequent referrals or follow-up consultations may be initiated by the AHP, as appropriate.	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; and						
	4. Patient's medical records						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17D.3.1.7							
Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference (i.e. AHP act, SOP, CPG, etc)						

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TOPIC 17D.4
FACILITIES AND EQUIPMENT

STANDARD 17D.4.1
Safe and adequate facilities and equipment are available for the delivery of effective Speech-Language Therapy Services and ensuring patient safety.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17D.4.1.1							
There is appropriate access to the facility, adequate facilities and equipment with proper utilization of space to enable staff to carry out their professional, teaching, and administrative functions.	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; and						
	5. Absence of overcrowding.						
CRITERION 17D.4.1.2							
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); and						
	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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Planned Preventive Maintenance records such as schedule, stickers, etc.;						
	2. Planned Replacement Programme where applicable;						
	3. Complaint records; and						
	4. Asset inventory.						
CRITERION 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.	1. User training records;						
	2. Competency record;						
	3. Letter of authorisation; and						
	4. List of staff trained and privileged to operate specialised equipment.						
CRITERION 17D.4.1.5 (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care.						

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TOPIC 17D.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 17D.5.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17D.5.1.1							
There are periodical 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; and g) Innovation.	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; and						
	5. Records on innovation if available						
CRITERION 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.	1. Minutes of Meetings;						
	2. Letter of assignment of responsibilities; and						
	3. Job description.						
CRITERION 17D.5.1.3							
The Head of the Speech-Language Therapy Services shall ensure that	1. System for incident reporting is in place, which include:						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.taken within the agreed time frame to prevent recurrence.	a. Training of staff;						
	b. Policy on incident reporting;						
	c. Methodology of incident reporting; and						
	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; and						
	8. Feedback given to staff regarding incident reporting.						
CRITERION 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%);	1. Specific performance indicators monitored;						
	2. Records on tracking and trending analysis; and						
	3. Remedial measures taken where appropriate.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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: ≥85%); d) Percentage of Stroke and Traumatic Brain Injury patients with swallowing difficulties (Dysphagia) who achieve at least FOIS Level 4 within 4 months of treatment. (Target: ≥90%); and e) Percentage of patient satisfaction towards speech-language therapy services. (Target: ≥85%).							
CRITERION 17D.5.1.5 (NEW)							
The Services participates in the Facility's safety culture assessment. The results are utilized by Service leadership to inform and guide efforts to improve the culture of safety within the Service.	1. Safety Culture Survey for staff						
CRITERION 17D.5.1.6							

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Feedback on results of safety and performance improvement activities are regularly communicated to the staff to promote transparency, shared learning, and active engagement in improvement initiatives.	1. Results of safety and performance improvement activities are accessible to staff through education sessions, meetings and digital communications.						
CRITERION 17D.5.1.7							
Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.	1. Documentation on performance improvement activities and performance indicators; and						
	2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						

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SERVICE SUMMARY	
OVERALL RATING :	-
OVERALL RISK :	-

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SERVICE STANDARD 17E: ALLIED HEALTH PROFESSIONAL SERVICES – AUDIOLOGY SERVICES

PREAMBLE

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.

TOPIC 17E.1
ORGANISATION AND MANAGEMENT

STANDARD 17E.1.1

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.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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 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.	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 are measurable in line with the Facility statements available, endorsed and dated; and						
	3. These statements are communicated to all staff (orientation programme, minutes of meeting, etc)						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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; and d) Is revised when there is a major change in any of the following: i) Organisation; ii) Functions; iii) Reporting relationships; and iv) Staffing patterns.	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; and						
	3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).						
CRITERION 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	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 service;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
and privacy of patients and confidentiality of their personal information; b) Assure continuity of care; c) Address the professional needs of audiology staff; and d) Ensure the relevant staff are involved in the formulation of policies and procedures concerning audiology care appropriate to the scope of services of the Facility.	c. Record on continuity of care in patient's medical treatment record; and						
	d. Professional Development Plan.						
CRITERION 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.	1. Minutes are accessible, disseminated and acknowledged by the staff;						
	2. Attendance list of members with adequate representation of the service;						
	3. Frequency of meetings as scheduled; and						
	4. Discussion and resolutions are implemented.						
CRITERION 17E.1.1.5							
The Head of Audiology Services is involved in the planning, justification and management of	1. Minutes of Facility-wide management meeting;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
the budget and resource utilisation of the services	2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service; and						
	3. Approved budget and resources.						
CRITERION 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; and						
	3. Records of staff deployment						
CRITERION 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.	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;					

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	f. Data on performance improvement activities, including performance indicators (i.e. clinical audit, /research, /innovation etc).						
CRITERION 17E.1.1.8 (NEW)							
The Head of Services shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	1. Documented and approved BCP for unanticipated situations;						
	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment.						
	3. Clear actions and staff responsibilities during disruption.						
	4. Record of drills or tests, with follow-up actions, if conducted.						
	5. Review of Risk Register.						

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TOPIC 17E.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD 17E.2.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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 audiologists shall be registered following the requirements of the Allied Health Professions Act.	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; and						
	4. Training and competency records including privileging.						
CRITERION 17E.2.1.2							
The authority, responsibilities and accountabilities of the Head of Audiology Services are clearly delineated and documented.	1. Appointment letter for Head of audiology services, and						
	2. Description of duties and responsibilities.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Number of staff and qualification should commensurate with workload and regulatory requirements;						
	2. Audiologists and support staff with appropriate qualifications, training and experience are available;						
	3. Staffing pattern;						
	4. Duty roster; and						
	5. Census and statistics.						
CRITERION 17E.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;	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; and						
	4. The job description is acknowledged by the staff and signed by the Head of Service and dated.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
iv) Qualifications required and privileges granted; v) Staffing patterns; and vi) Statutory Regulations. e) Administrative and clinical functions.							
CRITERION 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.	1. Staff personal records include:						
	a. Curricular Vitae (CV);						
	b. Qualification and experience;						
	c. Training record;						
	d. Competency record and/or credentialing and privileging;						
	e. Leave record; and						
	f. Confidentiality agreement.						
CRITERION 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.	1. Policy requiring all new staff to attend a structured orientation programme;						
	2. Records on structured orientation programme;						
	3. Orientation Brief; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	4. List of attendance.						
CRITERION 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.	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; and						
	4. Training module						
CRITERION 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.	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; and						
	4. Certificate of attendance/degree/post grad training.						
CRITERION 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.	1. Performance appraisal for staff is completed upon probationary period and as an annual exercise.						
CRITERION 17E.2.1.10							

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.	1. Letter of appointment – Local Preceptor/ Clinical Instructor;						
	2. Memorandum of Understanding with training institution;						
	3. Adequate number of clinical instructor to students; and						
	4. Qualification and training records of local preceptor						

STANDARD 17E.2.2 (NEW)

The audiology services shall be responsible for promoting and supporting the physical, mental and spiritual well-being of the audiology staff, ensuring a safe and healthy work environment.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17E.2.2.1 (CORE)							
The audiology services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being.	1. Documented Policies and Procedures Staff Well-Being Policy (covering physical, mental, and spiritual health); and						
	2. Monitoring and Review Mechanisms Staff wellbeing surveys, feedback reports and actions.						
CRITERION 17E.2.2.2 (CORE)							
The audiology services shall establish a safe mechanism for audiology staff to express grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in	1. Audiology staff suggestions, grievance reporting and processing mechanisms are available;						
	2. The resolution of workplace issues may involve the following:						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
accordance with the principles of psychological safety.	a. Policy and procedures for the protection of the whistleblower;						
	b. Anonymous reports received from staff;						
	c. Staff orientation modules to include violence and whistleblower protection, bullying, and harassment;						
	d. Awareness campaigns to promote safe workplace culture; and						
	e. Training and adherence to documented policies and procedures for violence activation and audiology staff protection.						
CRITERION 17E.2.2.3 (NEW)							
A system shall be created to gather audiology staff feedback about their workplace experience such as burnout which shall be analysed and used to make improvements that enhance the work environment, audiology staff satisfaction, and organisation culture.	1. Staff feedback (e.g., minutes of sessions or staff satisfactions survey):						
	a. Evidence of action or improvement taken.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17E.2.2.4 (NEW)							
The audiology services shall track sick leave and audiology staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning	1. Workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments; and						
	2. The results shall be used to create focused actions that improve audiology staff well-being, solve problems, and help retain audiology employees.						

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TOPIC 17E.3
POLICIES AND PROCEDURES

STANDARD 17E.3.1
DEVELOPMENT, DERIVATION AND DOCUMENTATION
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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, current standard practices and Patients and Family Rights. 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..	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; and						
	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; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	4. The policies and procedures are endorsed and dated.						
CRITERION 17E.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) Prevention and control of infection; g) Referral guidelines; and h) Communication – within and outside the Audiology Services. Cross-departmental collaboration is practiced 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. Clinical documentation covers 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);						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	d. Evidence of discharge/transfer plan;						
	e. Documentation of transfer of care; and						
	f. Original referral forms.						
	6. Care plan and discharge plan						
CRITERION 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.	1. Policy for Code Blue within the service area; and						
	2. Flow chart and contact number of Code Blue made available and accessible.						
CRITERION 17E.3.1.4							
Current policies and procedures are communicated to all staff.	1. Training and briefing on the current policies and procedures/Minutes of meetings; and						
	2. Circulation list and acknowledgement.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17E.3.1.5							
There is evidence on compliance with policies and procedures.	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; and						
	d. Practices in line with established policies and procedures.						
CRITERION 17E.3.1.6							
All outpatients seeking consultation or treatment with the Audiology Services shall receive an initial referral from a medical practitioner to an Allied Health Professional (AHP). Subsequent referrals or follow-up consultations may be initiated by the AHP, as appropriate.	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; and						
	4. Patient's medical records.						
CRITERION 17E.3.1.7							
Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws, and statutory requirements ie: AHP act						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Laws and statutory requirements are accessible to staff.	774, Audiology Standard operating procedures (SOP) are accessible on site for staff reference.						

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TOPIC 17E.4
FACILITIES AND EQUIPMENT

STANDARD 17E.4.1
Safe and adequate facilities and equipment are available for the delivery of effective audiology services and ensuring patient safety.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17E.4.1.1							
There is appropriate access to the facility, adequate facilities and equipment with proper utilization of space to enable staff to carry out their professional, teaching, and administrative functions.	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; and						
	5. Absence of overcrowding.						
CRITERION 17E.4.1.2							
All audiometric booth and audiometers are to be certified by relevant companies registered under Department of	1. Equipment is placed in a planned and systematic manner as evidenced on site;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Occupational Safety and Health (DOSH) or authorize by the manufacturer or principal distributor:	2. Certificate of room calibration by relevant company registered under Department of Occupational Safety and Health (DOSH);						
	3. The equipment used to calibrate the audiometric booth and audiometer shall use a type/class 1 sound level meter (SLM) with a valid calibration certificate issued by the manufacturer or laboratory accredited by the department of stand Malaysia; and						
	4. In the event of the Audiometric testing Centre (ATC) of the establishment is conducting audiometric screening for workers exposed to excessive noise, the requirement of the occupational safety and health (noise regulation) 2019 (OSHA 2019) shall be applied to the sound booth registered.						
CRITERION 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); and						
	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.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Planned Preventive Maintenance records such as schedule, stickers, etc.;						
	2. Planned Replacement Programme where applicable;						
	3. Complaint records; and						
	4. Asset inventory.						
CRITERION 17E.4.1.5 (CORE)							
Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.	1. User training records;						
	2. Competency assessment record;						
	3. Letter of authorisation; and						
	4. List of staff trained and competent to operate specialised equipment.						
CRITERION 17E.4.1.6 (CORE)							
Alarm system for emergencies appropriate to client needs shall be made available.	1. Emergency alert alarm system, i.e. mechanical and Code Blue is in place.						
CRITERION 17E.4.1.7 (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care.						

TOPIC 17E.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 17E.5.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17E.5.1.1							
There are periodical 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; and g) Innovation	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; and						
	5. Records on innovation if available.						
CRITERION 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.	1. Minutes of meetings;						
	2. Letter of assignment of responsibilities; and						
	3. Job description.						
CRITERION 17E.5.1.3							
The Head of the Audiology Services shall ensure that the staff are trained and complete incident reports which are promptly	1. System for incident reporting is in place, which include:						
	a. Training of staff;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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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.	b. Policy on incident reporting;						
	c. Methodology of incident reporting; and						
	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; and						
	8. Feedback given to staff regarding incident reporting.						
CRITERION 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 patients received hearing aid provision following the diagnosis of hearing loss within 8 weeks. (Target: ≥90%); b) Percentage of babies who failed the Universal Newborn Hearing Screening (UNHS) and underwent a hearing test before the age of 3 months. (Target: > 70%);	1. Specific performance indicators monitored;						
	2. Records on tracking and trending analysis; and						
	3. Remedial measures taken where appropriate.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
c) Percentage of newborn babies who underwent hearing screening (Universal Newborn Hearing Screening) within 28 days after birth. (Target: ≥60%); and d) Percentage of paediatric new cases given an appointment at the Audilogy clinic within 60 days from the date of receiving the referral. (Target: ≥50%)							
CRITERION 17E.5.1.5 (NEW)							
The Services participates in the Facility's safety culture assessment. The results are utilized by Service leadership to inform and guide efforts to improve the culture of safety within the Service.	1. Safety Culture Survey for staff						
CRITERION 17E.5.1.6							
Feedback on the results of safety and performance improvement activities are regularly communicated to the staff to promote transparency, shared learning, and active engagement in improvement initiatives.	1. Results on safety and performance improvement activities are accessible to staff through education sessions, meetings and digital communications.						
CRITERION 17E.5.1.7							
Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.	1. Documentation on performance improvement activities and performance indicators; and						
	2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						

SERVICE SUMMARY	
OVERALL RATING :	-
OVERALL RISK :	-

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SERVICE STANDARD 17F: ALLIED HEALTH PROFESSIONAL SERVICES – OPTOMETRY SERVICES

PREAMBLE

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).

TOPIC 17F.1
ORGANISATION AND MANAGEMENT

STANDARD 17F.1.1

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.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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 are measurable in line with the Facility statements available, endorsed and dated;						
	3. Evidence of planned reviews of the above statements (at least once in 3 years or in the event of any major changes);						
	4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc); and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.						
CRITERION 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; and d) Is revised when there is a major change in any of the following: i) Organisation; ii) Functions; iii) Reporting relationships; and iv) Staffing patterns	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; and						
	3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).						
CRITERION 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 patients in the Facility in a safe, efficient, effective, and	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 service;					

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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 speech-language therapy staff; and 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.	c. Record on continuity of care in patient's medical treatment record; and d. Professional Development Plan.						
CRITERION 17F.1.1.4							
Regular staff meetings are held between the Head of Optometry 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 representation of the service; 3. Frequency of meetings as scheduled; and 4. Discussion and resolutions are implemented.						
CRITERION 17F.1.1.5							
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						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	resources (staffing, equipment, etc); and						
	3. Approved budget and resources.						
CRITERION 17F.1.1.6							
The Head of Optometry Services is involved in the appointment and/OR assignment of the staff.	1. Appointment/assignment letter of Head of Optometry;						
	2. Job description of Head of Optometry;						
	3. Records of staff deployment; and						
	4. Duty Roster.						
CRITERION 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.	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; and						
	f. Data on performance improvement activities, including performance indicators (i.e. Clinical audit, /research, /innovation etc).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17F.1.1.8 (NEW)							
The Head of Services shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	1. Documented and approved BCP for unanticipated situations; 2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment. 3. Clear actions and staff responsibilities during disruption; 4. Record of drills or tests, with follow-up actions, if conducted; and 5. Review of Risk Register.						

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TOPIC 17F.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD 17F.2.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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; and						
	5. Training and competency records.						
CRITERION 17F.2.1.2							
The authority, responsibilities and accountabilities of the Head of Optometry Services are clearly delineated and documented.	1. Appointment/assignment letter for Head of Optometry services, and						
	2. Description of duties and responsibilities.						
CRITERION 17F.2.1.3 (CORE)							
Sufficient numbers of optometrists with appropriate	1. Number of staff and qualification should commensurate with workload;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
qualifications are employed to meet the needs of the services	2. Staffing pattern;						
	3. Duty roster; and						
	4. Census and statistics.						
CRITERION 17F.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; v) Staffing patterns; and 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; and						
	4. The job description is acknowledged by the staff and signed by the Head of Service and dated.						
CRITERION 17F.2.1.5							
Personnel records on training, staff development, leave and	1. Staff personal records include:						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
others are maintained for every staff. **Note:** Staff personal record may be kept in Human Resource Department as per Facility policy	a. Curriculum Vitae (CV);						
	b. Qualification and experience;						
	c. Evidence of current registration;						
	d. Training record;						
	e. Competency record and/or credentialing and privileging;						
	f. Leave record; and						
	g. Confidentiality agreement.						
CRITERION 17F.2.1.6 (NEW)							
There is a structured orientation programme for all newly appointed, contracted and outsourced staff to the Services that include but not limited to the following: General a) Vision and mission of the Facility; b) Organisation chart and reporting structure of the Facility; c) Environment and facility safety policies and procedures including sustainability practices; d) Infection control policies and procedures;	1. Policy requiring all new staff to attend a structured orientation programme;						
	2. There is Services orientation programme with relevant topics not limited to topics covered from (a) to (q); and						
	3. Attendance list.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
e) policies for performance management, patient safety (IPSG/MPSG) and risk management; f) Ethical practices and code of conduct including medicolegal awareness; g) Management of aggression, violence and harassment; and h) Patient and family rights <u>Services</u> i) Goals, objectives and organisational structure of Services; j) Policies and procedures relevant to Services; k) Working instructions for patient care; and l) Service continuity plan for Services in response to internal and external disasters. <u>Job-specific</u> m) Explanation of particular duties and functions; n) Explanation of the methods of assigning clinical care and the standards of clinical practice; o) Handover communication; p) Training in basic/advanced life support techniques; and q) Technology and equipment use including artificial intelligence, digital care and robotic.							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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; and						
	4. Training module (if applicable).						
CRITERION 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.	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; and						
	4. Certificate of attendance.						
CRITERION 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.	1. Performance appraisal for staff is completed upon probationary period and as an annual exercise.						
CRITERION 17F.2.1.10							
In a Facility where education programs are conducted, the	1. Letter of appointment – Local Preceptor/Clinical Instructor;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Facility shall ensure that there are sufficient skilled trained staff to provide clinical supervision of students.	2. Memorandum of Understanding with training institution;						
	3. Adequate number of Local Preceptor/Clinical Instructor to student; and						
	4. Qualification and training records of local preceptor (if applicable).						

STANDARD 17F.2.2 (NEW)

The Optometry Services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the Optometry Services staff, ensuring a safe and healthy work environment.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17F.2.2.1 (CORE)							
The Optometry services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being.	1. Documented Policies and Procedures Staff Well-Being Policy (covering physical, mental, and spiritual health); and						
	2. Monitoring and Review Mechanisms Staff wellbeing surveys, feedback reports and actions.						
CRITERION 17F.2.2.2 (CORE)							
The Optometry Services shall establish a safe mechanism for Optometry Services staff to express grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with	1. Optometry Services staff suggestions and grievance reporting and processing mechanisms are available.						
	2. The resolution of workplace issues may involve the following:						
	a. Measures and evidence of Optometry Services staff protection including						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
the principles of psychological safety.	whistleblowers against violence, bullying, and harassment e.g., awareness campaigns, anonymous reporting channel, Whistleblower policy; and						
	b. Documented policies and procedures for violence activation and Optometry Services staff protection.						
CRITERION 17F.2.2.3 (NEW)							
A system shall be created to gather staff feedback about their workplace experience such as burnout which shall be analysed and used to make improvements that enhance the work environment, staff satisfaction, and organisation culture.	1. Staff feedback (e.g., minutes of sessions or staff satisfactions survey):						
	a. Evidence of action or improvement taken.						
CRITERION 17F.2.2.4 (NEW)							
The Optometry Services shall track sick leave and Optometry Services staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning	1. Workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments. The results shall be used to create focused actions that improve staff well-being, solve problems, and help retain employees.						

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TOPIC 17F.3
POLICIES AND PROCEDURES

STANDARD 17F.3.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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, current standard practices and Patients and Family Rights. 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.	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; and						
	4. The policies and procedures are endorsed and dated.						
CRITERION 17F.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 practiced 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 (if applicable); and						
	3. Documented cross departmental policies (if applicable).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Policy for Code Blue within the service area; and						
	2. Flow chart and contact number of Code Blue made available and accessible.						
CRITERION 17F.3.1.4							
Current policies and procedures are communicated to all staff.	1. Training and briefing on the current policies and procedures/Minutes of meetings; and						
	2. Circulation list and acknowledgement.						
CRITERION 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; and c) Provide appropriate instruction to patients	1. Standard Operating Procedures (SOP) shall cover items (a) to (d);						
	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; and					
		d. Practices in line with established policies and procedures.					

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17F.3.1.6							
All outpatients seeking consultation or treatment with the Optometry Services shall receive an initial referral from a medical practitioner to an Allied Health Professional (AHP). Subsequent referrals or follow-up consultations may be initiated by the AHP, as appropriate.	1. Facility policy on referral to allied health services by medical practitioner;						
	2. Referral letter/referral form written by medical practitioner/certified optometrist/ school health team /AVIS program;						
	3. All patients/clients are registered in the manual register book or electronic system; and						
	4. Patient's medical record.						
CRITERION 17F.3.1.7							
Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.	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						

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TOPIC 17F.4
FACILITIES AND EQUIPMENT

STANDARD 17F.4.1
Safe and adequate facilities and equipment are available for the delivery of effective optometry services and ensuring patient safety.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17F.4.1.1							
There is appropriate access to the facility, adequate facilities, and equipment with proper utilization of space to enable staff to carry out their professional, teaching, and administrative functions.	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; and						
	5. Absence of overcrowding.						
CRITERION 17F.4.1.2							
There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.	1. Adequate equipment and supplies for optometry services;						
	2. Testing, commissioning and calibration records (certificates or stickers); and						
	3. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	Malaysia (SIRIM), etc as evidence of compliance to the relevant.						
CRITERION 17F.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.	1. Planned Preventive Maintenance records such as schedule, stickers, etc.;						
	2. Planned Replacement Programme where applicable;						
	3. Complaint records; and						
	4. Asset inventory.						
CRITERION 17F.4.1.4 (CORE)							
Where specialised equipment is used, there is evidence that only staff who are trained and authorized by the Facility operate such equipment.	1. User training records;						
	2. Competency assessment record; and						
	3. List of staff trained and competent to operate specialised equipment.						
CRITERION 17F.4.1.5 (CORE)							
Examination room shall be set up according to standards to enable precise measurement.	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.						
CRITERION 17F.4.1.6 (CORE)							
Alarm system for emergencies appropriate to client needs shall be made available.	1. Emergency alert alarm system i.e. mechanical and Code Blue is in place.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17F.4.1.7 (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care.						

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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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17F.5.1.1							
There are periodical 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; and g) Innovation.	1. Planned performance improvement activities include (a) to (g);						
	2. Records on performance improvement activities;						
	3. Minutes of performance improvement meetings; and						
	4. Performance improvement studies.						
CRITERION 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.	1. Minutes of meetings;						
	2. Letter of assignment of responsibilities; and						
	3. Job description.						
CRITERION 17F.5.1.3							
The Head of the Optometry Services shall ensure that the staff	1. System for incident reporting is in place, which include:						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.	a. Training of staff;						
	b. Policy on incident reporting;						
	c. Methodology of incident reporting; and						
	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; and						
	8. Feedback given to staff regarding incident reporting.						
CRITERION 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	1. Specific performance indicators monitored;						
	2. Records on tracking and trending analysis; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
RGP contact lens delivery. (Target: ≤20%); b) Optometrist outreach (Target: twice a year achieved 100%); c) New Cases Achieve Best Vision Level of 6/6 After Refractive Examination. (Target: ≥90%) d) Percentage new patient that were given an appointment for refraction procedure within ≤ 6 weeks in Optometry Clinic without Ophthalmologist. (Target: ≥85%) e) Percentage new patient that were given an appointment for diabetic retinopathy screening within ≤6 weeks in Optometry Clinic at Klinik Kesihatan. (Target:≥80%); and f) Waiting time to see optometrist after registration (Target: 80% within 60 minutes)	3. Remedial measures taken where appropriate.						
CRITERION 17F.5.1.5 (NEW)							
The Services participates in the Facility's safety culture assessment. The results are utilized by Service leadership to inform and guide efforts to improve the culture of safety within the Service.	1. Safety Culture Survey for staff.						
CRITERION 17F.5.1.6							
Feedback on the results of safety and performance improvement activities are regularly	1. Results on safety and performance improvement activities are accessible to staff through						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
communicated to the staff to promote transparency, shared learning, and active engagement in improvement initiatives.	education sessions, meetings and digital communications.						
CRITERION 17F.5.1.7							
Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.	1. Documentation on performance improvement activities and performance indicators; and						
	2. Policy statement on anonymity on patients and providers involved in performance improvement activities. e.g: Patients and Family Rights policy.						

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SERVICE SUMMARY	
OVERALL RATING :	-
OVERALL RISK :	-

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SERVICE STANDARD 17H : ALLIED HEALTH PROFESSIONAL SERVICES – MEDICAL SOCIAL WORK SERVICES

PREAMBLE

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 involves 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 the local community.

TOPIC 17H.1
ORGANISATION AND MANAGEMENT

STANDARD 17H.1.1

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.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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	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 are measurable in line with the Facility statements are available, endorsed and dated;						
	3. Evidence of planned reviews of the above statements (at least once in 3 years or in the event of any major changes);						
	4. These statements are communicated to all staff						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
all staff.accordingly and communicated to all staff.	(orientation programme, minutes of meeting, etc); and						
	5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.						
CRITERION 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; and d) Is revised when there is a major change in any of the following: a. Organisation; b. Functions; c. Reporting relationships; and d. Staffing patterns.	1. Clearly delineated current organization 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; and						
	3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).						
CRITERION 17H.1.1.3							
The Governing Body shall ensure that Medical Social Work	1. The Medical Social Services is organised to cover activities but not limited to items (a) to (e) through:						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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 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 medical social work staff; and 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.	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; and						
	e. Informed Consent Form is provided to protect the privacy and confidentiality of the patient's information.						
	2. Consultation rooms are conducive for the 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; and						
	4. Participation and involvement in inter and multi-disciplinary review team.						
CRITERION 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,	1. Minutes are accessible, disseminated and acknowledged by the staff;						
	2. Attendance list of members with adequate representation of the service;						
	3. Frequency of meetings as scheduled; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
communicated to all staff of the service, and implemented.	4. Discussion and resolutions are implemented.						
CRITERION 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 the Human Resource Department as per Facility policy.	1. Staff personal records include:						
	a. Curricular Vitae (CV);						
	b. Qualification and experience;						
	c. Evidence of current registration;						
	d. Training record;						
	e. Competency record and/or credentialing and privileging;						
	f. Leave record; and						
	g. Confidentiality agreement.						
CRITERION 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.	1. Minutes of Facility-wide management meeting;						
	2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	3. Approved budget and resources.						
CRITERION 17H.1.1.7							
The Head of Medical Social Work Services is involved in the assignment of staff	1. Appointment/assignment letter of Head of Service;						
	2. Job description of Head of Service; and						
	3. Records on staff deployment.						
CRITERION 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.	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; and						
	f. Data on performance improvement activities, including performance indicators.						
CRITERION 17H.1.1.9 (NEW)							
The Head of Services shall ensure a basic Business Continuity Plan (BCP) is in place	1. Documented and approved BCP for unanticipated situations;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment.						
	3. Clear actions and staff responsibilities during disruption;						
	4. Record of drills or tests, with follow-up actions, if conducted; and						
	5. Review of Risk Register.						

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TOPIC 17H.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD 17H.2.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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 a Bachelor Degree of Social Science with Honor (Social Work	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; and						
	4. Training and competency records.						

DISTRIBUTION

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Studies) or equivalent or recognized by MQA.							
CRITERION 17H.2.1.2							
The authority, responsibilities and accountabilities of the Head of Medical Social Services are clearly delineated and documented.	1. Appointment/assignment letter for Head of Service; and						
	2. Description of duties and responsibilities.						
CRITERION 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.	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; and						
	d. Non-specialist facility.						
	2. Number of staff and qualification commensurate with workload;						
	3. Staffing pattern; and						
	4. Census and statistics.						
CRITERION 17H.2.1.4							
	1. Updated specific job description is available for each staff that includes						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and vi) Statutory Regulations.	but not limited to as listed in (a) to (d);						
	2. Job description; and						
	3. The job description is acknowledged by the staff and signed by the Head of Service and dated.						
CRITERION 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	1. Staff personal records include:						
		a. Curricular Vitae (CV);					
		b. Qualification and experience;					
		c. Evidence of current registration;					
		d. Training record;					

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	e. Competency record and/or credentialing and privileging;						
	f. Leave record; and						
	g. Confidentiality agreement.						
CRITERION 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.	1. Policy requiring all new staff to attend a structured orientation programme;						
	2. Records on structured orientation programme;						
	3. Orientation Brief; and						
	4. Attendance list						
CRITERION 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.	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; and						
	4. Training module.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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; and						
	4. Certificate of attendance/degree/post graduate training.						
CRITERION 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.	1. Performance appraisal for staff is completed upon probationary period and as an annual exercise.						
CRITERION 17H.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.	1. Letter of appointment – Local Preceptor;						
	2. Memorandum of Understanding with training institution;						
	3. Adequate number of clinical instructor to student; and						
	4. Qualification and training records of local preceptor .						

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STANDARD 17H.2.2 (NEW)

The Medical Social Work Services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the Medical Social Work Services staff, ensuring a safe and healthy work environment.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17H.2.2.1 (CORE)							
The medical social work services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being.	1. Documented Policies and Procedures Staff Well-Being Policy (covering physical, mental, and spiritual health); and						
	2. Monitoring and Review Mechanisms Staff wellbeing surveys, feedback reports and actions.						
CRITERION 17H.2.2.2 (CORE)							
The medical social work services shall establish a safe mechanism for medical social work staff to express grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety.	1. Medical social work staff suggestions, grievance reporting and processing mechanisms are available;						
	2. The resolution of workplace issues may involve the following:						
	a. Measures and evidence of medical social work services staff protection including whistleblowers against violence, bullying, and harassment e.g., awareness campaigns, anonymous reporting channel, Whistleblower policy; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	b. Documented policies and procedures for violence activation and medical social work staff protection.						
CRITERION 17H.2.2.3 (NEW)							
A system shall be created to gather medical social work staff feedback about their workplace experience such as burnout which shall be analysed and used to make improvements that enhance the work environment, medical social work staff satisfaction, and organisation culture.	1. Medical social work staff feedback (e.g., minutes of sessions or medical social work staff satisfactions survey):						
	a. Evidence of action or improvement taken.						
CRITERION 17H.2.2.4 (NEW)							
The medical social work services shall track sick leave and medical social work staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning	1. Workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments. The results shall be used to create focused actions that improve staff well-being, solve problems, and help retain employees..						

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TOPIC 17H.3
POLICIES AND PROCEDURES

STANDARD 17H.3.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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, current standard practices and Patients and Family Rights. These policies and procedures are signed, authorized, and dated, and reference made to relevant Acts/guidelines pertaining to psychosocial issues as follows: a) Child Act 2001; b) Domestic Violence Act 1994; c) Operational Management Plan for Medical Social Work Services (*Buku Pelan Pengurusan Operasi Perkhidmatan Kerja Sosial Perubatan*); d) Standard Operational Procedure for Support Therapy Assistance Management (*Buku Prosedur Operasi Standard Pengurusan Bantuan Terapi Sokongan*);	2. Documented policies and procedures for the Medical Social Work Services;						
	3. Policies and procedures are consistent with regulatory requirements and current standard practices that include issues addressed in (a) to (g);						
	4. 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;						
	5. Evidence of periodic review of policies and procedures; and						
	6. The policies and procedures are endorsed and dated.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
e) Standard Operational Procedure for Practical Assistance Management (*Buku Prosedur Operasi Standard Pengurusan Bantuan Praktic*); f) Practical Guidelines for medical social workers in the Ministry of Health (*Buku Garis panduan Laporan Sosio Ekonomi Pegawai Kerja Sosial Perubatan Kementerian Kesihatan Malaysia*); and g) 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.							
CRITERION 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;	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;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
e) Types of assistance; f) Monitoring and evaluation; and g) Consultation with the medical practitioner; and shall be recorded in the patient's medical record. Cross-departmental collaboration is practiced in developing relevant policies and procedures where applicable	b. Informed Consent Form for patient;						
	c. Biopsychosocial assessment form by Medical Social Work Officer:						
	d. Case note from by Medical Social Work Officer for case chronology						
CRITERION 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.	1. Policy for Code Blue within the service area; and						
	2. Flow chart and contact number of code blue made available and accessible.						
CRITERION 17H.3.1.4							
Current policies and procedures are communicated to all staff.	1. Training and briefing on the current policies and procedures/Minutes of meetings; and						
	2. Circulation list and acknowledgement.						
CRITERION 17H.3.1.5 (CORE)							
There is evidence of compliance with policies and procedures and standards of practice.	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; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	d. Practices in line with established policies.						
CRITERION 17H.3.1.6							
All outpatients seeking consultation or treatment with the Speech-Language Therapy Services shall receive an initial referral from a medical practitioner to an Allied Health Professional (AHP). Subsequent referrals or follow-up consultations may be initiated by the AHP, as appropriate.	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; and						
	4. Patient's medical record.						
CRITERION 17H.3.1.7							
Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.						

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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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17H.4.1.1							
There are adequate and appropriate facilities and equipment with proper utilization of space to enable staff to carry out their professional, teaching, and administrative functions.	1. Adequate and proper utilisation of space;						
	2. Adequate facilities and equipment for safe care. (e.g. access to emergency cart, hand washing facilities, etc);						
	3. Easy access and clear exit routes; and						
	4. Absence of overcrowding.						
CRITERION 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.	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.						
CRITERION 17H.4.1.3							
There is evidence that the facility has a comprehensive maintenance programme such as	1. Planned Preventive Maintenance records such as schedule, stickers, etc.;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
predictive maintenance, planned preventive maintenance, and calibration activities, to ensure the facilities and equipment are in good working order.	2. Planned Replacement Programme where applicable;						
	3. Complaint records; and						
	4. Asset inventory.						
CRITERION 17H.4.1.4 (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care.						

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TOPIC 17H.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 17H.5.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17H.5.1.1							
There are periodical 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; and g) Innovation.	1. Planned performance improvement activities include (a) to (g);						
	2. Records on performance improvement activities;						
	3. Minutes of performance improvement meetings;						
	4. Performance improvement studies; and						
	5. Records on innovation if available.						
CRITERION 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.	1. Minutes of meetings;						
	2. Letter of assignment of responsibilities; and						
	3. Job description.						
CRITERION 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	1. System for incident reporting is in place, which include:						
	a. Training of staff;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.	b. Policy on incident reporting;						
	c. Methodology of incident reporting; and						
	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. and						
	8. Feedback given to staff regarding incident reporting.						
CRITERION 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: 98%); and b) Percentage of cases referred to the referral agencies within five (5) working days after social intervention complete (Target: 85%) .	1. Specific performance indicators monitored;						
	2. Records on tracking and trending analysis; and						
	3. Remedial measures taken where appropriate.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17H.5.1.5 (NEW)							
The Services participates in the Facility's safety culture assessment. The results are utilized by Service leadership to inform and guide efforts to improve the culture of safety within the Service.	1. Safety Culture Survey for staff						
CRITERION 17H.5.1.6							
Feedback on the results of safety and performance improvement activities are regularly communicated to the staff to promote transparency, shared learning, and active engagement in improvement initiatives.	1. Results on safety and performance improvement activities are accessible to staff through education sessions, meetings and digital communications.						
CRITERION 17H.5.1.7							
Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.	1. Documentation on performance improvement activities and performance indicators; and						
	2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						

DRAFT NOT FOR DISTRIBUTION

SERVICE SUMMARY	
OVERALL RATING :	-
OVERALL RISK :	-

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SERVICE STANDARD 17I : ALLIED HEALTH PROFESSIONAL SERVICES – COUNSELLING PSYCHOLOGY SERVICES

PREAMBLE

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.

Counseling Psychology services are provided by:

a) Psychology Officer (Counseling) who are registered with the Malaysian Board of Counselor (Act 580)

TOPIC 17I.1
ORGANISATION AND MANAGEMENT

STANDARD 17I.1.1

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.

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.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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, indicating safety, quality, and client-centered care. These reflect the roles and aspirations of the	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 are measurable in line with the Facility statements available, endorsed and dated;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
service and the needs of the clients. These statements are monitored, reviewed, and revised as required accordingly and communicated to all staff.	3. Evidence of planned reviews of the above statements (at least once in 3 years or in the event of any major changes); and						
	4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc.)						
CRITERION 17I.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; and d) Is revised when there is a major change in any of the following: i) Organisation; ii) Functions; iii) Reporting relationships; and iv) Staffing patterns	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; and						
	3. The Organisation chart is revised when there is a major change in any of the items (d) (i) to (iv).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17I.1.1.3							
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; and 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	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; and					
		e. Informed Consent Form is provided to protect the privacy and confidentiality of the patient's information					
	2. Services provided ensure privacy and confidentiality:						
		a. Individual counselling room;					
		b. Group counselling room; and					
		c. Documented client record and summary progress report.					
CRITERION 17I.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	1. Minutes are accessible, disseminated and acknowledged by the staff;						
	2. Attendance list of members with adequate representation of the service;						
	3. Frequency of meetings as scheduled; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
during meetings shall be accessible, communicated to all staff of the service, and implemented	4. Discussion and resolutions are implemented.						
CRITERION 17I.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.	1. Minutes of Facility–wide management meeting;						
	2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service; and						
	3. Approved budget and resources.						
CRITERION 17I.1.1.6							
The Head of Counselling Psychology Services is involved in the appointment and/OR assignment of the staff.	1. Appointment/assignment letter of Head of Service;						
	2. Job description of Head of Service;						
	3. Records on staff deployment;						
	4. Staffing number and staff profile;						
	5. Staff training records; and						
	6. Duty roster.						
CRITERION 17I.1.1.7							
Appropriate statistics and records shall be maintained in	1. Policy on keeping client's treatment records.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
relation to the provision of Counselling Psychology Services and used for managing the services and clients care. All client's treatment records shall be kept according to relevant regulation.	2. Records are available but not limited to the following:						
	a. Workload/census;						
	b. Annual report;						
	c. Accident/incident reports; and						
	d. Data on performance improvement activities, including performance indicators.						
CRITERION 17I.1.1.8 (NEW)							
The Governing Body shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	1. Documented and approved BCP for unanticipated situations;						
	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment.						
	3. Clear actions and staff responsibilities during disruption;						
	4. Record of drills or tests, with follow-up actions, if conducted;						
	5. Review of Risk Register.						

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TOPIC 17I.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD 17I.2.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17I.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.	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; and						
	4. Training and competency records.						
CRITERION 17I.2.1.2							
The authority, responsibilities and accountabilities of the Head of Counselling Psychology Services are clearly delineated and documented.	1. Appointment letter for Head of Service; and						
	2. Description of duties and responsibilities.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17I.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.	1. Number of Psychology Officer (Counselling) and qualification should commensurate with workload;						
	2. Staffing pattern;						
	3. Duty roster; and						
	4. Census and statistics.						
CRITERION 17I.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) 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;	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; and					
		d. Consultation.					
	3. The job description is acknowledged by the staff and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
iii) General and specific accountabilities; iv) Qualifications required and privileges granted; v) Staffing patterns; and vi) Statutory regulations.	signed by the Head of Service and dated.						
CRITERION 17I.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	1. Staff personal records include:						
	a. Curricular Vitae (CV);						
	b. Qualification and experience;						
	c. Evidence of current registration;						
	d. Training record;						
	e. Competency record and/or credentialing and privileging;						
	f. Leave record; and						
	g. Confidentiality agreement.						
CRITERION 17I.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.	1. Policy requiring all new staff to attend a structured orientation programme;						
	2. Records on structured orientation programme.;						
	3. Orientation Brief; and						
	4. Attendance list.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17I.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.	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; and						
	4. Training module.						
CRITERION 17I.2.1.8							
There are continuing education activities for staff to pursue professional interests and to prepare for current and future changes in practice.	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; and						
	4. Certificate of attendance/degree/post graduate training.						
CRITERION 17I.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.	1. Performance appraisal for staff is completed upon probationary period and as an annual exercise.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17I.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.	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; and						
	5. Clinical student logbook.						

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STANDARD 17I.2.2 (NEW)

The counselling psychology services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the counselling psychology staff, ensuring a safe and healthy work environment.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17I.2.2.1 (CORE)						
The counselling psychology services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being.	1. Documented Policies and Procedures Staff Well-Being Policy (covering physical, mental, and spiritual health); and 2. Monitoring and Review Mechanisms Staff wellbeing surveys, feedback reports and actions.					
CRITERION 17I.2.2.2 (CORE)						
The Counselling Psychology Services shall establish a safe mechanism for counselling psychology staff to express grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety.	1. Documented policies and procedures for violence activation and Counselling Psychology Services staff protection. 2. The resolution of workplace issues may involve the following: a. Counselling psychology staff suggestions, grievance reporting and processing mechanisms are available; and b. Measures and evidence of psychology services staff protection including Risk Management and Safety Procedure. e.g.; PFA.					
CRITERION 17I.2.2.3 (NEW)						
A system shall be created to gather staff feedback about their workplace experience such as burnout which shall be analysed and used to make improvements	1. Staff feedback (e.g., minutes of sessions or staff satisfactions survey): a. Evidence of action or improvement taken.					

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
that enhance the work environment, staff satisfaction, and organisation culture.							
CRITERION 17I.2.2.4 (NEW)							
The counselling psychology services shall track sick leave and counselling psychology staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning	1. Workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments. The results shall be used to create focused actions that improve staff well-being, solve problems, and help retain employees.						

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TOPIC 17I.3
POLICIES AND PROCEDURES

STANDARD 17I.3.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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, current standard practices and Patients and Family Rights. 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.	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; and						
	4. The policies and procedures are endorsed and dated.						
CRITERION 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. A documentation of counseling and psychological care plan, which includes:	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; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
a) Assessment; b) Diagnosis c) Intervention; d) Monitoring and evaluation; e) Consultation with the treatment practitioner shall be recorded in the client's treatment record Cross-departmental collaboration is practiced in developing relevant policies and procedures where applicable	4. Clinical documentation in client's treatment records includes clear record of assessment; diagnosis; intervention; monitoring and evaluation.						
CRITERION 17I.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 cases, trauma, and crisis cases) is available.	1. Policy for Code Blue and Code Grey within the service area; and						
	2. Flow chart and contact number of Code Blue and Code Grey made available and accessible.						
CRITERION 17I.3.1.4							
Current policies and procedures are communicated to all staff.	1. Training and briefing on the current policies and procedures/Minutes of meetings; and						
	2. Circulation list and acknowledgement.						
CRITERION 17I.3.1.5 (CORE)							
There is evidence of compliance with policies and procedures and standards of practice.	1. Compliance with policies and procedures through:						
	a. Interview of staff on practices;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	b. Verify with observation on practices;						
	c. Results of audit on practices; and						
	d. Practices in line with established policies and procedures						
CRITERION 17I.3.1.6							
All clients seeking consultation or treatment with the Counselling Psychology Services shall receive an initial referral from a medical practitioner to an Allied Health Professional (AHP). Subsequent referrals or follow-up consultations may be initiated by the AHP, as appropriate. **Note:** Staffs are allowed to walk in for counseling sessions by self-referral.	1. Facility policy on referral to allied health services by Medical Practitioner;						
	2. Referral letter/referral form written by Medical Practitioner;						
	3. All clients are registered in the manual register book or electronic system; and						
	4. Client's treatment record.						
CRITERION 17I.3.1.7							
Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws, and Statutory requirements are accessible on-site for staff reference.						

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TOPIC 17I.4
FACILITIES AND EQUIPMENT

STANDARD 17I.4.1
Appropriate, safe and adequate facilities and equipment are available for the delivery of effective Counselling Psychology Services and ensuring clients safety.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17I.4.1.1 (CORE)							
There are adequate and appropriate facilities and equipment with proper utilization of space to enable staff to carry out their professional, teaching, and administrative functions.	1. Adequate and proper utilisation of space:						
	a. Individual counselling room;						
	b. Group counselling room; and						
	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; and						
	b. Hand washing facilities/ emergency cart.						
	4. Easy access and clear exit routes; and						
	5. Absence of overcrowding.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17I.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.	1. Suitable rooms for counseling session (such as sofa, coffee table, air condition and etc)						
	2. List of Psychological Assessment and educational tools.						
CRITERION 17I.4.1.3							
There is documented evidence that psychological instruments and assessment comply where applicable, with relevant standards.	1. Psychological assessment and educational tools used.						
CRITERION 17I.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.	1. Planned Preventive Maintenance records such as schedule, stickers, etc;						
	2. Planned Replacement Programmed where applicable;						
	3. Complaint records; and						
	4. Asset inventory.						
CRITERION 17I.4.1.5							
Where specialized equipment, psychological assessment, and educational tools are used, there	1. License and certificate of the user of psychological assessment and educational tools;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
is evidence that only staff who are trained and authorized by the Facility operate such equipment.	2. User training records;						
	3. Competency assessment record; and						
	4. List of staff trained and authorized to psychological assessment and educational tools.						
CRITERION 17I.4.1.6 (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care.						

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TOPIC 17I.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 17I.5.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17I.5.1.1							
There are periodical 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; and g) Innovation	1. Specific performance indicators monitored;						
	2. Records on tracking and trending analysis;						
	3. Remedial measures taken where appropriate; and						
	4. Records on innovation if available.						
CRITERION 17I.5.1.2							
The Head of Counselling Psychology Services has assigned the responsibilities for planning, monitoring, and managing safety and performance improvement to appropriate individuals/personnel within the respective services.	1. Minutes of meetings;						
	2. Letter of assignment of responsibilities; and						
	3. Job description.						
CRITERION 17I.5.1.3							
The Head of Counselling Psychology Services shall ensure	1. System for incident reporting is in place, which include:						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
that the staff are trained and complete incidents, 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.	a. Training of staff;						
	b. Policy on incident reporting;						
	c. Methodology of incident reporting; and						
	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; and						
	8. Feedback given to staff regarding incident reporting.						
CRITERION 17I.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.	1. Specific performance indicators monitored;						
	2. Records on tracking and trending analysis; and						
	3. Remedial measures taken where appropriate.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17I.5.1.5 (NEW)							
The Services participates in the Facility's safety culture assessment. The results are utilized by Service leadership to inform and guide efforts to improve the culture of safety within the Service.	1. Safety Culture Survey for staff.						
CRITERION 17I.5.1.6							
Feedback on the results of safety and performance improvement activities is regularly communicated to the staff to promote transparency, shared learning, and active engagement in improvement initiatives.	1. Results on safety and performance improvement activities are accessible to staff through education sessions, meetings and digital communications.						
CRITERION 17I.5.1.7							
Appropriate documentation of safety and performance improvement activities is kept and confidentiality of Medical Practitioners, staff and clients is preserved.	1. Documentation on performance improvement activities and performance indicators; and						
	2. Policy statement on anonymity on clients and providers involved in performance improvement activities.						

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SERVICE SUMMARY	
OVERALL RATING :	-
OVERALL RISK :	-

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SERVICE STANDARD 17J : ALLIED HEALTH PROFESSIONAL SERVICES – CLINICAL PSYCHOLOGY SERVICES

PREAMBLE

Clinical Psychology Services shall offer recognition, assessment, diagnosis, treatment, rehabilitation, and prevention of cognitive, emotional, and behavioral dysfunction and learning disorder to improve clinical symptoms and enhance the subject's well-being, mental health, and life functioning using evidence-based and scientist-practitioner model as well as utilizing clinical application of psychological principle.

The services are part of a multidisciplinary team for psychological readjustment and restoration to psychological fitness.

TOPIC 17J.1
ORGANISATION AND MANAGEMENT

STANDARD 17J.1.1

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.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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	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 are measurable in line with the Facility statements available, endorsed and dated;						
	3. Evidence of planned reviews of the above statements (at least once in 3 years or in the event of any major changes);						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
accordingly and communicated to all staff by the organisation or designated service.	4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc); and						
	5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.						
CRITERION 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; and d) Is revised when there is a major change in any of the following: i) Organisation; ii) Functions; and iii) Reporting relationships;	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; and						
	3. The organisation chart is revised when there is a major change in any of the items (d) (i) to (iv).						
CRITERION 17J.1.1.3							
The Governing Body shall ensure that Clinical Psychology Services are organised in such a way as to:	1. The Clinical Psychology Services is organised to cover activities but not limited to items (a) to (e) through:						
	a. Work assignment schedule to ensure service provision;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and e) Address the professional needs development of the Clinical Psychologist;	b. Competent staffing level to provide the necessary service;						
	c. Record on continuity of care in client's treatment record; and						
	d. Professional Development Plan.						
	2. Services provided ensure person-centred treatment, privacy and						
	a. Sessions are conducted in a safe and private manner; and						
	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.						
CRITERION 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.	1. Minutes are accessible, disseminated and acknowledged by the staff;						
	2. Attendance list of members with adequate representation of the service;						
	3. Frequency of meetings as scheduled; and						
	4. Discussion and resolutions are implemented.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Minutes of Facility–wide management meeting;						
	2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service; and						
	3. Approved budget and resources.						
CRITERION 17J.1.1.6							
The Head of Clinical Psychology Services in the organisation is involved in the appointment and/OR assignment of the staff.	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; and						
	5. Duty roster.						
CRITERION 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.	1. Policy on keeping patient's medical records						
	2. Records are available but not limited to the following:						
	a. Workload/census;						
	b. Annual report;						
	c. Accident/incident reports (if applicable);						
	d. Staffing number and staff profile;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	e. Staff training records; and						
	f. Data on performance improvement activities, including performance indicators.						
CRITERION 17J.1.1.8 (NEW)							
The Governing Body shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	1. Documented and approved BCP for unanticipated situations;						
	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment.						
	3. Clear actions and staff responsibilities during disruption;						
	4. Record of drills or tests, with follow-up actions, if conducted; and						
	5. Review of Risk Register.						

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TOPIC 17J.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD 17J.2.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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; and						
	4. Training and competency records.						
CRITERION 17J.2.1.2							
The authority, responsibilities and accountabilities of the Head of Clinical Psychology Services are clearly delineated and documented.	1. Appointment/assignment letter for Head of Service; and						
	2. Description of duties and responsibilities.						
CRITERION 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.	1. Number of competent clinical psychologists and support staff commensurate with workload;						
	2. Staffing pattern;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	3. Duty roster; and						
	4. Census and statistics.						
CRITERION 17J.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; and 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; and						
	3. The job description is acknowledged by the staff and signed by the Head of Service and dated.						
CRITERION 17J.2.1.5							
Personnel records on training, staff development, leave and others are maintained for every staff.	1. Staff personal records include:						
	a. Curricular Vitae (CV);						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Note: Staff personal record may be kept in Human Resource Department as per Facility policy	b. Qualification and experience;						
	c. Evidence of current registration;						
	d. Training record;						
	e. Competency record and/or credentialing and privileging;						
	f. Leave record; and						
	g. Confidentiality agreement						
CRITERION 17J.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.	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; and						
	4. Attendance list.						
CRITERION 17J.2.1.7							
There is evidence of training needs assessment and staff	1. Training needs assessment is carried out and gaps identified;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
development plan which provides the knowledge and skills required for staff to maintain competency in their current positions and future advancement.	2. A staff development plan based on training needs assessment is available;						
	3. Training schedule/calendar is in place; and						
	4. Training module.						
CRITERION 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	1. Continuing education activities and schedule;						
	2. Contents of training program;						
	3. Training records on continuing education activities are kept and maintained for each staff; and						
	4. Certificate of attendance/degree/post basic training.						
CRITERION 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.	1. Performance appraisal for staff is completed upon probationary period and as an annual exercise.						
CRITERION 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.	1. Facility Usage Guideline, Ministry of Health Malaysia (Garis Panduan Penggunaan Fasiliti KKM);						
	2. Letter of appointment – Local Preceptor/Clinical Instructor;						
	3. Memorandum of Understanding with training institution;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	4. Adequate number of clinical instructors to students;						
	5. Qualification and training records of local preceptor; and						
	6. Clinical Student Logbook.						

STANDARD 17J.2.2 (NEW)

The clinical psychology services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the clinical psychology staff, ensuring a safe and healthy work environment.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17J.2.2.1 (CORE)							
The clinical psychology services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being.	1. Documented Policies and Procedures Staff Well-Being Policy (covering physical, mental, and spiritual health); and						
	2. Monitoring and Review Mechanisms Staff wellbeing surveys, feedback reports and actions.						
CRITERION 17J.2.2.2 (CORE)							
The clinical psychology services shall establish a safe mechanism for clinical psychology staff to express grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with	1. Clinical psychology staff suggestions, grievance reporting and processing mechanisms are available						
	2. The resolution of workplace issues may involve the following:						
	a. Measures and evidence of Rehabilitation Medicine Services staff protection						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
the principles of psychological safety.	including whistleblowers against violence, bullying, and harassment e.g., awareness campaigns, anonymous reporting channel, Whistleblower policy; and						
	b. Documented policies and procedures for violence activation and Clinical Psychology Services staff protection.						
CRITERION 17J.2.2.3 (NEW)							
A system shall be created to gather staff feedback about their workplace experience such as burnout which shall be analysed and used to make improvements that enhance the work environment, staff satisfaction, and organisation culture.	1. Staff feedback (e.g., minutes of sessions or staff satisfactions survey)						
	a. Evidence of action or improvement taken.						
CRITERION 17J.2.2.4 (NEW)							
The clinical psychology services shall track sick leave and clinical psychology staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning	1. Workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) are regularly checked for trends and compared across departments. The results shall be used to create focused actions that improve staff well-being, solve problems, and help retain employees.						

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TOPIC 17J.3
POLICIES AND PROCEDURES

STANDARD 17J.3.1
DEVELOPMENT, DERIVATION AND DOCUMENTATION
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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, current standard practices and Patients and Family Rights. 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.	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 (Garis Panduan Penggunaan Fasiliti);					
		c. Pelan Pengurusan Operasi Profesion Psikologi Klinikal;					
		d. Standard Operation Procedure Profesion Psikologi Klinikal; and					
		e. Allied Health Act 774					
	2. Policies and procedures are consistent with regulatory requirements and current standard practices;						
	3. Evidence of periodic review of policies and procedures; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	4. Policies and procedures are updated, endorsed and dated.						
CRITERION 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 i) 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.	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; and 6. Informed consent document.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Cross-departmental collaboration is practiced in developing relevant policies and procedures where applicable							
CRITERION 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.	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 are; and						
	5. Flow chart and contact number of Code Blue made available and accessible.						
CRITERION 17J.3.1.4							
Current policies and procedures are communicated to all staff.	1. Training and briefing on the current policies and procedures/Minutes of meetings; and						
	2. Circulation list and acknowledgement.						
CRITERION 17J.3.1.5 (CORE)							
There is evidence of compliance with policies and procedures and standards of practice.	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; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	e. Practices in line with established policies and procedures.						
CRITERION 17J.3.1.6							
All outpatients seeking consultation or treatment with the Clinical Psychology Services shall receive an initial referral from a medical practitioner to an Allied Health Professional (AHP). Subsequent referrals or follow-up consultations may be initiated by the AHP, as appropriate.	1. Facility policy on referral to allied health services by medical practitioner/specialist through written or digital referral format; and						
	2. Patient's medical record.						
CRITERION 17J.3.1.7							
Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.	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.						

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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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17J.4.1.1 (CORE)							
There is appropriate access to the facility, adequate facilities and equipment with proper utilization of space to enable staff to carry out their professional, teaching and administrative functions.	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; and						
	c. Adequate lighting and minimal noise.						
	5. Easy access and clear exit routes.						
	6. Absence of overcrowding.						
CRITERION 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.	1. Standardized equipment (cognitive, personality, adaptive, etc.) for all age range of patient;						
	2. Equipments are replaced and updated accordingly; and						
	3. There is record of registration of clinical psychology facilities and equipment/instruments.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17J.4.1.3							
There is documented evidence that clinical psychological instrument/equipment complies with relevant national/international standards and current statutory requirements.	1. Testing, commissioning and calibration records (certificates or stickers); and						
	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.						
CRITERION 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.	1. Planned Preventive Maintenance records such as schedule, stickers, etc;						
	2. Planned Replacement Programme where applicable;						
	3. Complaint records; and						
	4. Asset inventory.						
CRITERION 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.	1. User training records for specific psychological equipment/instruments;						
	2. Competency assessment record;						
	3. Letter of authorisation; and						
	4. List of staff trained and authorised to operate specialised equipment.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17J.4.1.6							
Alarm system for emergencies appropriate to patient needs shall be made available.	1. Panic button, mechanical device such as phone or bell on site at patient therapy room.						
CRITERION 17J.4.1.7 (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care.						

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TOPIC 17J.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 17J.5.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17J.5.1.1							
There are periodical 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; and g) Innovation	1. Planned performance improvement activities include (a) to (g);						
	2. Records on performance improvement activities;						
	3. Minutes of performance improvement meetings;						
	4. Performance improvement studies; and						
	5. Records on innovation if available.						
CRITERION 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.	1. Minutes of meetings; and						
	2. Letter of assignment of responsibilities.						
CRITERION 17J.5.1.3							
The Head of Clinical Psychology Services shall ensure that the staff	1. System for incident reporting is in place, which include:						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
are trained and complete incidents, 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 timeframe to prevent recurrence.	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; and						
	8. Feedback given to staff regarding incident reporting.						
CRITERION 17J.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 Psychological Assessment Completed within 30 working days (Target :85% - 90%)	1. Specific performance indicators monitored;						
	2. Records on tracking and trending analysis; and						
	3. Remedial measures taken where appropriate.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
b) Percentage of new patient referred to psychotherapy session receiving first session within 90 working days (Target: 80%) c) Percentage of Psychoeducation given in the first session. (Target 85%) d) Percentage of relapse cases (where applicable)							
CRITERION 17J.5.1.5 (NEW)							
The Services participates in the Facility's safety culture assessment. The results are utilized by Service leadership to inform and guide efforts to improve the culture of safety within the Service.	1. Safety Culture Survey for staff.						
CRITERION 17J.5.1.6							
Feedback on the results of safety and performance improvement activities is regularly communicated to the staff to promote transparency, shared learning, and active engagement in improvement initiatives.	1. Results on safety and performance improvement activities are accessible to staff through education sessions, meetings and digital communications.						
CRITERION 17J.5.1.7							
Appropriate documentation of safety and performance improvement activities is kept and confidentiality of Medical Practitioners, staff and clients is preserved.	1. Documentation on performance improvement activities and performance indicators; and						
	2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17J.5.1.8							
The Head of Services shall identify the role of Clinical Psychologist in the management of crisis and disaster in accordance to the organisation or department needs and requirement.	1. Job description of staff involvement in crisis and disaster management; and						
	2. Crisis and disaster emergency or contingency plan of the organisation.						

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SERVICE SUMMARY	
OVERALL RATING :	-
OVERALL RISK :	-

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SERVICE STANDARD 18 : PHARMACY SERVICES

PREAMBLE

Pharmacy Services shall provide safe and efficient delivery of the following activities:

a) Evaluation, appraisal and recommendation for selection of pharmaceutical products;
b) Procurement, storage, distribution and delivery of pharmaceutical products;
c) Manufacturing and reprocessing of pharmaceutical products;
d) Drug information, dissemination and patient counseling;
e) Poison information and advisory services;
f) Clinical pharmacy services; and
g) Harm reduction therapy services, e.g. Methadone dispensing, counseling on smoking cessation.

TOPIC 18.1
ORGANISATION AND MANAGEMENT

STANDARD 18.1.1

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.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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	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 are measurable in line with the Facility statements available, endorsed and dated;						
	3. Evidence of planned reviews of the above statements (at least once in						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
accordingly and communicated to all staff.	3 years or in the event of any major changes);						
	4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc); and						
	5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.						
CRITERION 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;reflect the link to relevant medical subspecialties services/units; b) Is accessible to all staff and clients; and c) Is revised when there is a major change in any of the following: i) Organisation; ii) Functions; iii) Reporting relationships; and iv) Staffing patterns All off-site and satellite pharmacies under the purview of Pharmacy Services shall be	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; and						
	3. The organisation chart is revised when there is a major change in any of the items (d) (i) to (iv).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
included in the main organisation chart.							
CRITERION 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.	1. Minutes are accessible, disseminated and acknowledged by the staff;						
	2. Attendance list of members with adequate representation of the service;						
	3. Frequency of meetings as scheduled; and						
	4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).						
CRITERION 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	1. Minutes of Facility-wide management meeting;						
	2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service; and						
	3. Approved budget and resources.						
CRITERION 18.1.1.5							
The Head of Pharmacy Services is involved in the appointment and/OR assignment of staff.	1. Records on staff interview (if applicable);						
	2. Appointment/assignment letter of staff;						
	3. Job description of Head of Service;						
	4. Records on staff deployment; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	5. Duty roster.						
CRITERION 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.	1. Minutes of meeting /memo/ letter.						
CRITERION 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.	1. Procurement record;						
	2. Inventory control record;						
	3. Audit report;						
	4. Drug information record; and						
	5. Safety and performance improvement activities.						
CRITERION 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; b) Clinical pharmacy services include: i) Quality use of medicines (dosage, indication for use, efficacy, adverse reactions, drug interaction and food	1. Specific services provided by the Pharmacy Services shall include items (a) to (d).						
	a. List of medicines with animal origin;						
	b. Patient consent on animal origin related medicines;						
	c. Record of patient counselling; and						
	d. Record of training attended.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
interactions, patient consent for animal origin related medicines that affect their religious beliefs and in terms of legal requirements), where appropriate; ii) Clinical pharmacokinetics services; c) Educational services i) Medicines usage and counselling for patients; ii) Drug information and advisory services; iii) Continuing education for pharmacy staff, medical, nursing, and other staff. d) 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							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
stored but issued for immediate use). iv) Participate in research in pharmacy services to improve medicine related therapy and utilisation; where applicable;							
CRITERION 18.1.1.9							
Where there are decentralised sections of the Pharmacy Services, specific objectives are documented.	1. Objectives for decentralised sections of the Pharmacy Services are specified and documented.						
CRITERION 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.	1. Records are available but not limited to the following:						
	a. Workload/census for all pharmacy services;						
	b. Annual report;						
	c. Accident/incident reports;						
	d. Staffing number and staff profile;						
	e. Staff training records; and						
	f. Data on performance improvement activities, including performance indicators.						
CRITERION 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	1. Letters of appointment of members to the Pharmacy and Therapeutic Committee;						
	2. Terms of reference include items (a) to (f);						
	3. Regular scheduled meeting;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; e) Medication safety including medication error, high alert medication etc f) Make recommendations regarding policies and procedures on the management of drugs.	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; and						
	8. Drug Formulary being established and revised periodically						
CRITERION 18.1.1.12							
Pharmacy Services maintain good communication with Governing Body, medical professionals and nursing staff through relevant committees and continuing education programmes.	1. Minutes of Facility-wide meetings/interdepartmental meetings / committee meetings;						
	2. Interdepartmental policies and procedures; and						
	3. Continuing medical education programme;						
CRITERION 18.1.1.13 (NEW)							
The Head of Services shall ensure a basic Business	1. Documented and approved BCP for unanticipated situations.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment.						
	3. Clear actions and staff responsibilities during disruption;						
	4. Record of drills or tests, with follow-up actions, if conducted; and						
	5. Review of Risk Register.						

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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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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/ pharmacist in charge possess a valid license in accordance to Act and Regulation;						
	3. Appointment/assignment letter; and						
	4. Job description.						
CRITERION 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.	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; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	3. Training and competency records.						
CRITERION 18.2.1.3 (CORE)							
There is a structured orientation programme for all newly appointed, contracted and outsourced staff to the Services that include but not limited to the following: General a) Vision and mission of the Facility; b) Organisation chart and reporting structure of the Facility; c) Environment and facility safety policies and procedures including sustainability practices; d) Infection control policies and procedures; e) Policies for performance management, patient safety (IPSG/MPSG) and risk management; f) Ethical practices and code of conduct including medicolegal awareness; g) Management of aggression, violence and harassment; and h) Patient and family rights Services i) Goals, objectives and organisational structure of Services;	1. Policy requiring all new staff to attend a structured orientation programme; 2. There is Services orientation programme with relevant topics not limited to topics covered from (a) to (q); and 3. Attendance list.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
j) Policies and procedures relevant to Services; k) Working instructions for patient care; l) service continuity plan for Services in response to internal and external disasters. <u>Job-specific</u> m) Explanation of particular duties and functions; n) Explanation of the methods of assigning clinical care and the standards of clinical practice; o) Handover communication; p) Training in basic/advanced life support techniques; and q) Technology and equipment use including artificial intelligence, digital care and robotics							
CRITERION 18.2.1.4							
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.	1. Appointment/assignment letter for Head of Service; and 2. Description of duties and responsibilities.						
CRITERION 18.2.1.5							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the need of the services.	1. Number of staff and qualification should commensurate with workload;						
	2. Staffing pattern;						
	3. Duty roster; and						
	4. Census and statistics.						
CRITERION 18.2.1.6							
There is a registered pharmacist on duty or on call at all times.	1. Availability of duty roster of pharmacist.						
CRITERION 18.2.1.7							
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;	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; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
d) Reviewed when required, 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; and vi) Statutory Regulations. e) Administrative and clinical functions.	4. The job description is acknowledged by the staff and signed by the Head of Service and dated.						
CRITERION 18.2.1.8							
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.	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; and						
	g. Confidentiality agreement.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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,	1. Performance appraisal for staff is completed upon probationary period and as an annual exercise.						
CRITERION 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.	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 and						
	4. Training module.						
CRITERION 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.	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; and						
	4. Certificate of attendance/degree/post basic training.						

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STANDARD 18.2.2 (NEW)

The pharmacy services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the pharmacy staff, ensuring a safe and healthy work environment.

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				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 18.2.2.1 (CORE)						
The pharmacy services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being. a) A health-promoting environment, e.g., stress management, burnout, staff engagement opportunities, workload monitoring, management of work life balance, healthy, lifestyle programmes e.g. Workplace Wellness Programs, Community-Based Health Initiatives; b) Staff shall be provided with appropriate supervision, support, and advice e.g., mentor mentee program; and c) There shall be clear procedures for the effective management of underperformance e.g., feedback on performance review or performance appraisal report.	1. The promotion of staff well-being may involve the following: a. Evidence of a health promoting environment e.g., workplace wellness programme; b. Evidence of proper supervision of staff; and c. Evidence of staff appraisal programme with feedback on underperformance.					

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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CRITERION 18.2.2.2 (CORE)							
The pharmacy services shall establish a safe mechanism for pharmacy staff to express grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety.	1. Pharmacy staff suggestions and grievance reporting and processing mechanisms are available;						
	2. The resolution of workplace issues may involve the following:						
	a. Measures and evidence of pharmacy staff protection including whistleblowers against violence, bullying, and harassment e.g., awareness campaigns, anonymous reporting channel, Whistleblower policy; and						
	b. Documented policies and procedures for violence activation and pharmacy staff protection.						
CRITERION 18.2.2.3 (NEW)							
A system shall be created to gather staff feedback about their workplace experience such as burnout which shall be analysed and used to make improvements that enhance the work environment, staff satisfaction, and organisation culture.	1. Staff feedback (e.g., minutes of sessions or staff satisfactions survey):						
	a. Evidence of action or improvement taken.						
CRITERION 18.2.2.4 (NEW)							
The pharmacy services shall track sick leave and pharmacy staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning	1. Evidence that workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments. The results shall be used to create focused actions that						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	improve staff well-being, solve problems, and help retain employees.						

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TOPIC 18.3
POLICIES AND PROCEDURES

STANDARD 18.3.1
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.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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, current standard practices and Patients and Family Rights. 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.	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 its Regulations, Dangerous Drug Act 1952, Sales of Drug Act, and Medicines 1952 Advertisements and Sale Act 1956 and other relevant guidelines;						
	3. Evidence of periodic review of policies and procedures; and						
	4. The policies and procedures are endorsed and dated.						
CRITERION 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	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; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
reference to relevant sources involved. Cross departmental collaboration is practiced in developing relevant policies and procedures where applicable	3. Documented cross departmental policies.						
CRITERION 18.3.1.3 (CORE)							
Current policies and procedures are communicated to all staff.	1. Training and briefing on the current policies and procedures/Minutes of meetings; and						
	2. Circulation list and acknowledgement.						
CRITERION 18.3.1.4 (CORE)							
There is evidence of compliance with policies and procedures.	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						
CRITERION 18.3.1.5 (CORE)							
There are policies and procedures on supplying / dispensing of medications which include: a) Screening, filling, counterchecking and	1. Policies and procedures on supplying/ dispensing of medication include (a) to (p);						
	2. Prescription / medication chart / indent form of floor stock;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
supplying/ dispensing in accordance to Good Dispensing Practice Guideline; b) Inventory control systems; c) Emergency medication supply after office hour; d) Storage of all medicines within the facility with respect to statutory regulations and any other requirements; e) A drug recall procedure; f) Security of the pharmacy services and storage areas at all times; g) Complaints procedure; h) Incorporation of inpatient and outpatient medication orders into the patient's medical record; i) Recording in the patient's medical record for every dose of medicine administered; j) Keeping accurate and accessible records on medicines supplied / dispensed and administered to inpatients and outpatients; k) Administering of medicines brought into the Facility by patients; l) Administering of medicines by patients, where appropriate; m) Access to patients' medical records, where appropriate; n) Abbreviations where used are in accordance with an	3. List of abbreviations;						
	4. Inventory record;						
	5. Monitoring of temperature for cold chain medications; and						
	6. 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.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
approved list by Pharmacy and Therapeutic Committee and endorsed by the Person In Charge (PIC); (revision) o) Reconstitution, storage and distribution of medication including cold chain management, transportation and administration of cytotoxic drugs; and p) Storage, preparation and transportation distribution of sterile preparation including cytotoxic drug, parenteral nutrition and radiopharmaceutical as well as non-sterile preparation							
CRITERION 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; and b) Provision of education and counselling as appropriate to patients and their families relating to medicines prescribed.	1. Policies and procedures on patient education and counselling include (a) and (b);						
	2. Record of counselling; and						
	3. Evidence of counselling materials (e.g. inhaler placebo, insulin pen, pamphlet, flipchart).						
CRITERION 18.3.1.7							
There are policies and procedures on manufacturing, reprocessing and storage of which include: a) Preparation of parenteral nutrition and labelling shall only be done by trained staff;	1. Policies and procedures on manufacturing, reprocessing and storage of medicines to include items (a) to (i);						
	2. Records on implementation process of (a) to (i);						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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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) Disposal of discontinued, outdated, or unwanted or unused portions of medications; h) Guidelines on spillage and decontamination (cytotoxic drugs and radiopharmaceuticals i) Quality control procedures to be carried out on products prepared in the Pharmacy Services.	3. Drug labels contain name and strength of medication, expiry date, batch number and name of manufacturer;						
	4. List of items/drugs/ preparations that require refrigeration and temperature monitoring;						
	5. Disposal record; and						
	6. Spillage kit and reporting of incident/spillage.						
CRITERION 18.3.1.8							
There are policies and procedures on drug information and advisory services. Active dissemination and provision of drug information shall be provided to healthcare professionals.	1. Policies and procedures on drug information and advisory services; and						
	2. Dissemination of information on drugs (e.g. pamphlet, newsletter, bulletin, circular, continuing medical education).						
CRITERION 18.3.1.9							
There is participation by the pharmacist in the adverse drug	1. Appropriate committee to discuss the ADR incidents;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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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.	2. Policies and procedures are in place for ADR reporting;						
	3. Sample of ADR reports and dissemination of findings; and						
	4. ADR reporting to Malaysian Adverse Drug Reporting Advisory Committee (MADRAC).						
CRITERION 18.3.1.10							
There are policies and procedures on monitoring and controlling of sample medications brought into the Facility.	1. Policies and procedures on monitoring and controlling of sample medications brought into the Facility; and						
	2. Records on monitoring and control of sample medications by Pharmacy Services.						
CRITERION 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 / Dangerous Drug; b) A drug recall procedure; c) Security of the Pharmacy Services and storage areas at all times; and d) Complaints procedure.	1. Policies and procedures of the Pharmacy Services that include items (a) to (d).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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CRITERION 18.3.1.12 (CORE)							
There are documented policies and procedures on prescribing medication that state: a) medication can only be dispensed by qualified pharmacy personnel based on prescription 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) Medication dispensed are based on the original of the medical practitioner's prescription. Drug orders are not transcribed.	1. Policies and procedures include (a) to (c) are available;						
	2. Security access is established for electronic prescribing;						
	3. Records on original prescription; and						
	4. Updated sample of doctors' signature for manual prescribing.						
CRITERION 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 sterile preparation including cytotoxic	1. Policy is in place for telephone ordering;						
	2. Written confirmation by the prescribing medical practitioner is obtained within 24 hours; and						
	3. Documentation of the verbal order by the receiving Medical Officer / Nurse in the patient record/ nursing note.						

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drugs/parenteral nutrition / radiopharmaceutical.							
CRITERION 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.	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; and						
	4. Report Medication Error to Medication Error Reporting System (MERS)						
CRITERION 18.3.1.15							
Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.						

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TOPIC 18.4
FACILITIES AND EQUIPMENT

Standard 18.4.1
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 and dedicated areas are required for services related to sterile preparation.

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CRITERION 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	1. Adequate and safe storage facilities are available and proper utilisation of space;						
	2. Easy access and clear exit routes;						
	3. Absence of overcrowding;						
	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; and						
	6. Floor plan/Physical layout inspection of storage conditions;						
	7. Special precautions for the storage of hazardous, sensitive, or dangerous materials; and						
	8. Special facilities for materials requiring specific storage conditions relating to temperature, humidity and other physical conditions.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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substances, highly toxic substances, cytotoxic drug, radiopharmaceutical materials, herbal drugs and remedies etc; and d) Special facilities shall be constructed and equipped for materials requiring specific storage conditions relating to temperature, humidity and other physical conditions.							
CRITERION 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 - 8ºc; iii) Freezer, temperature not more than -20ºc iv) Ultra-low, temperature between -65°C to -95°C; and v) Alarms or alerts need to be remotely connected	1. Daily Temperature monitoring records (including offsite not operating 24 hours);						
	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); and						
	6. Alarm tests and records (if applicable).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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available for refrigerator and freezer in pharmacy b) Humidity not more than 80%; 75%+_ 5 materials requiring dry or humidity control storage shall be stored in areas where the relative humidity and temperature is maintained within prescribed limits.; and c) Containment i) Inflammable or corrosive material requires effective ventilation and precautions to handle spillage; and ii) Radioactive material requires containment measures							
CRITERION 18.4.1.3							
Facilities for storing any psychotropic substances /Dangerous Drug 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), Dangerous Drugs Act and Regulations (1952) and in the Third Schedule of the Poisons Act 1952.	1. List of authorised personnel handling facilities for storing any psychotropic substances/Dangerous Drug;						
	2. Records on handing/taking over keys; and						
	3. On-site inspection on facilities for storing of psychotropic substances/Dangerous Drug.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 18.4.1.4 (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Any initiative or change of practice or policy that promote environmentally sustainable care.						
CRITERION 18.4.1.5							
There are adequate space, facilities, and equipment in the Pharmacy Services for compounding, repackaging, or reprocessing and dispensing of drug and with private area for patient counseling session. Designated and properly equipped areas are provided for the following: a) dispensing counter b) counseling area/room	1. Private area for patient counseling session.						
CRITERION 18.4.1.6							
There are adequate space, facilities, and equipment in the Pharmacy Services for repackaging and compounding of sterile and non-sterile preparations, including parenteral nutrition, intravenous admixtures, eye-drops, cytotoxic drugs, and radiopharmaceutical preparation. 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	1. Physical layout inspection to verify the following:						
		a. Adequate space, facilities, and equipment for compounding, repackaging of drug products including parenteral, intravenous admixtures, eye-drops, cytotoxic drugs, and radiopharmaceutical preparation; and					
		b. Designated and properly equipped areas for processes of (a) to (d).					

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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materials are contained and disposed of in a safe and approved manner; b) Preparation of radiopharmaceuticals in accordance with statutory regulations and Good Preparation Practice (GPP) guidelines; c) Preparation of parenteral nutrition, intravenous admixtures, eye-drops etc in accordance with statutory regulations and Good Manufacturing Practice (GMP) or Good Preparation Practice (GPP) guidelines depending on the services provided; and d) Preparation for extemporaneous and 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;							
CRITERION 18.4.1.7							
Security requirements for the Pharmacy Services shall address both facilities and staff protection including proper access controls and equipment.	1. Design and operational policy for controlled access and security of the pharmacy facilities; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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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.	2. Physical layout inspection of the pharmacy conforms to security and access control requirements.						
CRITERION 18.4.1.8							
There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.	1. Testing, commissioning record (certificates or stickers); and						
	2. Certification of equipment from certified bodies, e.g. Medical Device Act, Standards and Industrial Research Institute of Malaysia (SIRIM), etc whichever is applicable as evidence of compliance to the relevant standards and Acts.						
CRITERION 18.4.1.9							
The equipment used for measuring and monitoring shall be checked and calibrated /validated at suitable predetermined intervals and the results of such checks shall be recorded and retained. Measuring or monitoring equipment need to be calibrated/validated.	3. Records on planned preventive maintenance (PPM), corrective maintenance and calibration / validation on equipment used for measuring and monitoring.						
CRITERION 18.4.1.10							

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.	1. Planned Preventive and Predictive Maintenance records such as schedule, stickers, etc.						
	2. Planned Replacement Programme where applicable;						
	3. Complaint records; and						
	4. Asset inventory.						
CRITERION 18.4.1.11							
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, biosafety cabinets, isolators, etc.	1. User training records;						
	2. Competency assessment record;						
	3. Privileging certificate; and						
	4. List of staff trained and authorised to operate specialised equipment.						

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TOPIC 18.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 18.5.1
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.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 18.5.1.1							
There are periodical 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; and g) Innovation.	1. Planned performance improvement activities include (a) to (g);						
	2. Records on performance improvement activities;						
	3. Minutes of performance improvement meetings;						
	4. Performance improvement studies / analysis and evaluation; and						
	5. Records on innovation if available.						
CRITERION 18.5.1.2							
The Head of Pharmacy Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement to appropriate individual/personnel within the respective services.	1. Minutes of meetings;						
	2. Letter of assignment of responsibilities; and						
	3. Job description.						
CRITERION 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	1. System for incident reporting is in place, which include:						
	a. Training of staff;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.	b. Policy on incident reporting;						
	c. Methodology of incident reporting; and						
	d. 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; and						
	8. Feedback given to staff regarding incident reporting;						
CRITERION 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; and	1. Specific performance indicators monitored;						
	2. Records on tracking and trending analysis; and						
	3. Remedial measures taken where appropriate;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
d) Percentage and value of expired drugs at end of month over a specified period							
CRITERION 18.5.1.5 (NEW)							
The Services participates in the Facility's safety culture assessment. The results are utilized by Service leadership to inform and guide efforts to improve the culture of safety within the Service.	1. Safety Culture Survey for staff.						
CRITERION 18.5.1.6							
Feedback on results of safety and performance improvement activities are regularly communicated to the staff to promote transparency, shared learning, and active engagement in improvement initiatives.	1. Results on safety and performance improvement activities are accessible to staff through education sessions, meetings and digital communications.						
CRITERION 18.5.1.7							
Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.	1. Documentations on performance improvement activities and performance indicators; and						
	2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						

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SERVICE SUMMARY	
OVERALL RATING :	-
OVERALL RISK :	-

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SERVICE STANDARD 19: 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; and
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); and
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.

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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.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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 are measurable in line with the Facility statements available, endorsed and dated;						
	3. Evidence of planned reviews of the above statements (at least once in 3 years or in the event of any major changes).;						
	4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc); and						
	5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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; and d) Is revised when there is a major change in any of the following: i) Organisation; ii) Functions; iii) Reporting relationships; and iv) Staffing patterns.	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; and						
	3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv)						
CRITERION 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.	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; and						
	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.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Minutes are accessible, disseminated and acknowledged by the staff;						
	2. Attendance list of members with adequate representation of the service;						
	3. Frequency of meetings as scheduled; and						
	4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).						
CRITERION 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.	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; and						
	3. Approved budget and resources.						
CRITERION 19.1.1.6							
The Head of the CSSS is involved in the appointment and/OR assignment of the staff.	1. Records on staff interview (if applicable);						
	2. Appointment/assignment letter of Head of Service;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	3. Job description of Head of Service;						
	4. Records on staff deployment; and						
	5. Duty roster						
CRITERION 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.	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; and						
	f. Data on performance improvement activities, including performance indicators.						
CRITERION 19.1.1.8 (NEW)							
The Head of Services shall ensure a basic Business Continuity Plan (BCP) is	1. Documented and approved BCP for unanticipated situations;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment.						
	3. Clear actions and staff responsibilities during disruption;						
	4. Record of drills or tests, with follow-up actions, if conducted; and						
	5. Review of Risk Register.						

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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 19.1.2.1							
The services are approved by the Person In Charge (PIC) of the Facility.	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.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 19.1.2.2							
The external providers of the CSSS shall comply with all relevant MSQH Standards of Accreditation.	1. External providers of CSSS comply with the requirements of MSQH Standards for the service.						
CRITERION 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;	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); and					
		f. Meeting with external provider					

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
h) Involvement of the external service provider in safety and performance improvement activities of the Facility, as appropriate; and i) Comply with the appropriate MSQH Standards of Accreditation for CSSS which functions within the Facility.							

TOPIC 19.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD 19.2.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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; and						
	b. Described in the services' policy						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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; and						
	5. Training and competency records including training in infection control and privileging for specific job scope.						
CRITERION 19.2.1.3							
The authority, responsibilities and accountabilities of the Head of CSSS are clearly delineated and documented.	1. Appointment letter for Head of Service; and						
	2. Description of duties and responsibilities.						
CRITERION 19.2.1.4							
Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the need of the services.	1. Number of staff and qualification should commensurate with workload;						
	2. Staffing pattern;						
	3. Duty roster; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	4. Workload census and statistics.						
CRITERION 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.	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; and						
	4. The job description is acknowledged by the staff and signed by the Head of Service/Unit and dated.						
CRITERION 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	1. Staff personal records include:						
	a. Staff biodata;						
	b. Qualification and experience;						
	c. Training record;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	d. Competency record and privileging/authorisation to operate specialised equipment, e.g. Autoclave;						
	e. Leave record;						
	f. Confidentiality agreement; and						
	g. Immnunisation records.						
CRITERION 19.2.1.7 (CORE)							
Provision of vaccination programmes for all staff exposed to sharps injury and biological hazards.	1. Vaccination programme; and						
	2. Vaccination records.						
CRITERION 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.	1. Policy requiring all new staff to attend a structured orientation programme;						
	2. Records on structured orientation programme;						
	3. Orientation Brief; and						
	4. List of attendance.						
CRITERION 19.2.1.9 (CORE)							
There is a structured orientation programme for all newly appointed, contracted and outsourced staff to	1. Policy requiring all new staff to attend a structured orientation programme;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
the Services that include but not limited to the following: **General** a) Vision and mission of the Facility; b) Organization chart and reporting structure of the Facility; c) Environment and facility safety policies and procedures including sustainability practices; d) Infection control policies and procedures; e) Policies for performance management, patient safety (IPSG/MPSG) and risk management; f) Ethical practices and code of conduct including medicolegal awareness; g) Management of aggression, violence and harassment; and h) Patient and family rights. **Services** i) Goals, objectives and organizational structure of Services; j) Policies and procedures relevant to Services; k) Working instructions for patient care; and l) Service continuity plan for Services in response to internal and external disasters. **Job-specific** m) Explanation of particular duties and functions;	2. There is Services orientation programme with relevant topics not limited to topics covered from (a) to (q); and						
	3. Attendance list						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
n) Explanation of the methods of assigning clinical care and the standards of clinical practice; o) Handover communication; p) Training in basic/advanced life support techniques; and q) Technology and equipment use including artificial intelligence, digital care and robotics.							
CRITERION 19.2.1.10							
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.	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; and						
	4. Training module.						
CRITERION 19.2.1.11							
There are continuing education activities for staff to pursue professional interests and to prepare for current and future changes in practice.	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; and						
	4. Certificate of attendance/degree/post basic training.						
CRITERION 19.2.1.12							

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Staff receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.	1. Performance appraisal for staff is completed upon probationary period and as an annual exercise.						

STANDARD 19.2.2 (NEW)

The CSSS shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the nursing staff, ensuring a safe and healthy work environment.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 19.2.2.1 (CORE)							
The CSSS shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being. a) A health-promoting environment, e.g., stress management, burnout, staff engagement opportunities, workload monitoring, management of work life balance, healthy, lifestyle programmes e.g. Workplace Wellness Programs, Community-Based Health Initiatives; b) Staff shall be provided with appropriate supervision, support, and advice e.g., mentor mentee program; and c) There shall be clear procedures for the effective management of	1. The promotion of staff well-being may involve the following:						
		a. Evidence of a health promoting environment e.g., workplace wellness programme;					
		b. Evidence of proper supervision of staff; and					
		c. Evidence of staff appraisal programme with feedback on underperformance.					

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
underperformance e.g., feedback on performance review or performance appraisal report.							
CRITERION 19.2.2.2 (CORE)							
The CSSS shall establish a safe mechanism for nursing staff to express grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety.	1. Nursing staff suggestions and grievance reporting and processing mechanisms are available;						
	2. The resolution of workplace issues may involve the following:						
	a. Measures and evidence of nursing staff protection including whistleblowers against violence, bullying, and harassment e.g., awareness campaigns, anonymous reporting channel, Whistleblower policy; and						
	b. Documented policies and procedures for violence activation and central sterilising supply services staff protection.						
CRITERION 19.2.2.3 (NEW)							
A system shall be created to gather staff feedback about their workplace experience such as burnout which shall be analysed and used to make improvements that enhance the work environment, staff satisfaction, and organisation culture.	1. Staff feedback (e.g., minutes of sessions or staff satisfactions survey):						
	a. Evidence of action or improvement taken.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 19.2.2.4 (NEW)							
The CSSS shall track sick leave and staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning	1. Evidence that workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments. The results shall be used to create focused actions that improve CSSS staff well-being, solve problems, and help retain CSSS employees.						

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TOPIC 19.3
POLICIES AND PROCEDURES

STANDARD 19.3.1
DEVELOPMENT, DERIVATION AND DOCUMENTATION
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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, current standard practices and Patients and Family Rights. 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.	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; and						
	4. The policies and procedures are endorsed and dated.						
CRITERION 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	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; and						
	3. Documented cross departmental policies.						

DISTRIBUTION

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
control in Central Sterilising Supply Services.							
CRITERION 19.3.1.3							
Current policies and procedures are communicated to all staff.	1. Training and briefing on the current policies and procedures/Minutes of meetings; and						
	2. Circulation list and acknowledgement						
CRITERION 19.3.1.4 (CORE)							
There is evidence of compliance with hospital policies and procedures.	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; and						
	d. Practices in line with established policies and procedures.						
CRITERION 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;	1. Policies and procedures that address CSSS processes but not limited to items (a) to (n) are available.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and n) Management implantable items (mssa: malaysian standard of sterilization process) cross reference with infection control standard.							
CRITERION 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	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,						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
requirements of policies and procedures of the CSSS.	Cardiovascular Invasive Laboratory, Fertility Centre etc.						
CRITERION 19.3.1.7							
Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, ByLaws and statutory requirements are accessible to staff.	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference;						
	2. Equipment operating manuals;						
	3. Factory and Machinery Act;						
	4. Medical device operating manuals;						
	5. Occupational Safety and Health Act;						
	6. Infection Control Manual; and						
	7. Malaysian Standard of Sterilization Process (MSSA document)						
CRITERION 19.3.1.8							
Where single use devices or instruments are to be reused, the processes for reprocessing are consistent with relevant national guidelines and international standards.	1. Policy on reprocessing of single use devices; and						
	2. Observation on practice upon on-site inspection						
CRITERION 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	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;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
absence as per policy of the healthcare facility.	2. All tests performed on equipment and results; and						
	3. Steriliser records, e.g. number of cycles						

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TOPIC 19.4
FACILITIES AND EQUIPMENT

STANDARD 19.4.1
There are adequate facilities and equipment to enable the CSSS to meet its goals and objectives in accordance with regulatory requirements.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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) Receiving of unsterile supplies 1) Handling of supplies and equipment in accordance with planned stores and supply system and parking of carts. 2) Facilities for receiving, disassembling and cleaning of supplies and equipment shall be appropriately located avoiding	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; and						
	e. Absence of porous work benches at assembling and packaging area.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
non-sterile items passing through sterile areas of the CSSS. ii) Assembling and Packaging 1) 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) Sterilising 1) Facilities for sterilising shall be located between packaging area and sterile storage area. 2) An exhaust is installed over the back room of sterilisers to prevent condensation and heat building up. 3) A designated cooling area with good ventilation to							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
allow cooling of sterilised items. iv) Storage Facilities 1) Dedicated store for storage and issue of sterile instruments and supplies 2) Facilities for storage and issues of unsterilised linen for sterilization. 3) Facilities for storage and issue of unsterile instruments, 4) Facilities for storage and issue of chemical detergents and disinfectants 5) Facilities for storage of soft goods 6) 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.							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Adequate and proper utilisation of space;						
	2. Appropriate equipment to match the complexity of services; and						
	3. Easy access and clear exit routes.						
CRITERION 19.4.1.3							
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); and						
	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.						
CRITERION 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.	1. User training records;						
	2. Competency assessment record; and						
	3. List of staff trained and privileged to operate specialised equipment.						
CRITERION 19.4.1.5 (CORE)							
There is evidence that the Facility has a comprehensive maintenance programme such as	1. Planned Preventive Maintenance records such as schedule, stickers, etc;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.	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; and						
	5. Asset inventory.						
CRITERION 19.4.1.6 (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care.						

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TOPIC 19.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 19.5.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 19.5.1.1							
There are periodical planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the CSSS. The process includes: 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 and g) Innovation.	1. Planned performance improvement activities include (a) to (g);						
	2. Records on performance improvement activities/studies;						
	3. Minutes of performance improvement meetings;						
	4. CSSS risk register;						
	5. Evidence of risk register being reviewed; and						
	6. Records on innovation if available.						
CRITERION 19.5.1.2							
The Head of CSSS has assigned the responsibilities for planning, monitoring and managing safety	1. Collection, tabulation and verification of data;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
and performance improvement to appropriate individual/personnel within the respective services.	2. Discussed with relevant department;						
	3. Identify areas for improvement; and						
	4. Endorcement of outcome to Head of Nursing and PIC						
CRITERION 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.	1. System for incident reporting is in place, which include:						
		a. Training of staff;					
		b. Policy on incident reporting;					
		c. Methodology of incident reporting; and					
		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; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	8. Outcome of lesson learnt from the incident shared with other Feedback given to staff regarding incident reporting.						
CRITERION 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; and d) Leak testing for rigid container system to ensure sterility.	1. Specific performance indicators monitored;						
	2. Records on tracking and trending analysis;						
	3. Remedial measures taken where appropriate; and						
	4. Review performance indicators if trending shows consistent achievement over 1 year. Identify new performance indicators						
CRITERION 19.5.1.5 (NEW)							
The Services participates in the Facility's safety culture assessment. The results are utilized by Service leadership to inform and guide efforts to improve the culture of safety within the Service	1. Safety Culture Survey for staff.						
CRITERION 19.5.1.6							
Feedback on results of safety and performance improvement activities are regularly communicated to the staff to promote transparency, shared	1. Results on safety and performance improvement activities are accessible to staff through education sessions, meetings and digital communications.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
learning, and active engagement in improvement initiatives.							
CRITERION 19.5.1.7							
Appropriate documentation of safety and performance improvement activities are kept, and confidentiality of medical practitioners, staff and patients is preserved.	1. Documentation on performance improvement activities and performance indicators; and						
	2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						

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TOPIC 19.6
SPECIAL REQUIREMENTS

STANDARD 19.6.1
The CSSS shall be responsible for providing centralised sterilising services and sterile supplies for all areas within the Facility that use sterile instruments, dressings, linen and other items.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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; and f) Staff traffic flow.	1. Structural layout;						
		a. Physically demarcated zones for decontamination, packaging, sterilising, sterile store and distribution counter;					
		b. Good ventilation system with temperature and humidity control as per standard requirements;					
		c. Infection control aspects – appropriate personal protective equipment, staff changing room and hand washing facilities;					
		d. Workplace safety – staff safety, noise control, waste management; and					
		e. 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					

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	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;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	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;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	3. Mechanical and electrical installation:						
	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; and						
	d. Validation of installations (e.g. Testing and Commissioning records).						
	4. Appropriate equipment and fixtures:						
	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; and						
	iv. Magnify glass						
	c. Transportation trolley;						
	d. Sterilizer						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	5. Environmental control						
	a. All work areas shall maintain temperature between 20°C ±2 - 24°C; and						
	b. Temperature for sterile storage as per criterion 19.6.1.5 and humidity 55% +- 5						
	6. Fire safety system:						
	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; and						
	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.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	7. Staff traffic flow						
	a. For internal staff, there is designated route with sign posting between the demarcated zones; and						
	b. For external client, entrance and exit to the CSSS facility is restricted and compliance with dress code.						
CRITERION 19.6.1.2							
All sterilising systems (e.g. hot air, steam, gas) are maintained in accordance with statutory regulations.	1. Valid licence for steam sterilisers and other type of sterilisers; and						
	2. Log book of CSSS installation of vessels and chambers.						
CRITERION 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.	1. Separate room for linen inspection and preparation;						
	2. Illuminated linen inspection table; and						
	3. Exhaust system/Lint extractor						
CRITERION 19.6.1.4							
Arrangements are made for supplies required after normal office hours.	1. Policy on accessibility of Central Sterilising Supply Services for 24 hours;						
	2. On call roster of assigned staff to attend to CSSS; and						
	3. Mechanism to retrieve sterilised instruments from sources where not required.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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CRITERION 19.6.1.5 (CORE)							
In the sterile store, there is environmental control on ventilation with a positive pressure of 2.5 kpa, temperature (20ºC ± 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.	1. Appropriate temperature and humidity measurement devices;						
	2. Record of humidity and temperature readings; and						
	3. Records on corrective actions where there are deviations to the readings above.						
CRITERION 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.	1. Appropriate equipment to match complexity of the facility's services such as:						
		a. Washer disinfector • Dosage of detergent • Dosage of lubricant (if available) • Quality of water • Carried out test of Instrument - any cleaning verification that is reliable method for evaluating the cleaning effectiveness of the automated instrument washer and registered with the Medical Device Authority (MDA);					
		b. Ultrasonic machine • To check efficacy of ultrasonic wave • Any test to check efficacy of ultrasonic wave - ultrasonic washer (dosimeter) test and registered with the Medical Device Authority (MDA);					
		c. Dryer • Temperature monitoring;					

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	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. To provide oversight for the decontamination process hospital wide including in endoscopy unit;						
	h. Laparoscopic Insulation Tester; and						
	i. Validate for performance of Instrument containers use for sterilization						
CRITERION 19.6.1.7 (CORE)							
Validation tests on sterilisation process using mechanical, chemical and biological tests are conducted and results monitored and recorded accordingly.	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.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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	1. On-site inspection on compliance with (a) to (d).						
CRITERION 19.6.1.9							
Waste management 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	1. Policy on segregation and collection of waste.						
	2. Planned schedule by facilities.						
	3. Dedicated route.						
	4. Record of waste collection.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.							

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SERVICE SUMMARY	
OVERALL RATING :	
OVERALL RISK :	

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SERVICE STANDARD 20 : HOUSEKEEPING SERVICES

PREAMBLE

The Cleansing and Cleansing and Housekeeping Services to provide a pleasant, safe and sanitized environment to support optimum care for patient by complying with PHFS Act and MS 2757:2023 Cleansing Services for Healthcare Facilities Code of Practice.

TOPIC 20.1
ORGANISATION AND MANAGEMENT

STANDARD 20.1.1
The Cleansing and 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.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 20.1.1.1							
Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Cleansing and 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.	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body;						
	2. Goals and objectives of the Cleansing and Housekeeping Services are measurable in line with the Facility statements available, endorsed and dated;						
	3. Evidence of planned reviews of the above statements (at least once in 3 years or in the event of any major changes);						
	4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc); and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.						
CRITERION 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.	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Head and staff of Cleansing and Housekeeping Services;						
	2. Organisation chart of the service is endorsed, dated and accessible; and						
	3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).						
CRITERION 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 Cleansing and Housekeeping 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 representation of the service;						
	3. Frequency of meetings as scheduled; and						
	4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 20.1.1.4							
The Head of Cleansing and Housekeeping Services is involved in the planning, justification and management of the budget and resource utilisation of the services.	1. Minutes of Facility-wide management meeting;						
	2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service; and						
	3. Approved budget and resources.						
CRITERION 20.1.1.5							
The Head of Cleansing and Housekeeping Services is involved in the appointment and/OR assignment of staff.	1. Records on staff interview (if applicable);						
	2. Appointment/assignment letter of Head of Service;						
	3. Job description of Head of Service, duties and responsibilities;						
	4. Records on staff deployment; and						
	5. Duty roster.						
CRITERION 20.1.1.6							
Appropriate statistics and records shall be maintained in relation to the provision of Cleansing and Housekeeping Services and used for managing the services and patient care.	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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	f. Data on performance improvement activities, including performance indicators;						
	g. Customer feedback; and						
	h. Audit inspection records.						
CRITERION 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	1. Written agreement which includes 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; and						
	3. Evaluation of vendor for appointment						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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 Cleansing and Housekeeping Services which function within the Facility.							
CRITERION 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.	1. Appointment letter of liaison officer with terms of reference; and 2. Job description.						
CRITERION 20.1.1.9 (NEW)							
The Head of Services shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	1. Documented and approved BCP for unanticipated situations; 2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment. 3. Clear actions and staff responsibilities during disruption.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	4. Record of drills or tests, with follow-up actions, if conducted; and 5. Review of Risk Register.					

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TOPIC 20.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD 20.2.1
The Cleansing and Housekeeping Services shall be directed and adequately staffed with appropriately qualified and trained personnel to achieve the goals and objectives of the services.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 20.2.1.1							
The Head and staff of the Cleansing and Housekeeping Services shall be individuals qualified by education, training, and experience to commensurate with the requirements of the various positions.	1. Records on qualification and experience of Head of Service and staff related to housekeeping services.;						
	2. Appointment/assignment letters; and						
	3. Training and competency records.						
CRITERION 20.2.1.2							
The authority, responsibilities and accountabilities of the Head of Cleansing and Housekeeping Services are clearly delineated and documented.	1. Appointment/assignment letter for Head of Service; and						
	2. Description of duties and responsibilities						
CRITERION 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 based on manpower norm per areas	1. Number of staff and qualification and experience commensurate with workload;						
	2. Staffing pattern by adopting normal manpower norm and shift;						
	3. Duty roster; and						
	4. Census on workload.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 20.2.1.4 (CORE)							
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; and vi) Statutory Regulations.	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; and						
	4. The job description is acknowledged by the staff and signed by the Head of Service and dated.						
CRITERION 20.2.1.5 (CORE)							
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.	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						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	e. Leave record;						
	f. Confidentiality agreement; and						
	g. Immunisation records.						
CRITERION 20.2.1.6 (CORE)							
Provision of vaccination programmes for all staff exposed to sharps injury and biological hazards	1. Vaccination programme						
	2. Vaccination records						
CRITERION 20.2.1.7 (CORE)							
There is a structured orientation programme for all newly appointed, contracted and outsourced staff to the Services that include but not limited to the following: General a) Vision and mission of the Facility; b) Organisation chart and reporting structure of the Facility; c) Environment and facility safety policies and procedures including sustainability practices d) Infection control policies and procedures e) Policies for performance management, patient safety (IPSG/MPSG) and risk management f) Ethical practices and code of conduct including medicolegal awareness g) Management of aggression, violence and harassment	1. Policy requiring all new staff to attend a structured orientation programme;						
	2. There is Services orientation programme with relevant topics not limited to topics covered from (a) to (q); and						
	3. Attendance list.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
h) Patient and family rights <u>Services</u> i) Goals, objectives and organisational structure of Services; j) Policies and procedures relevant to Services; k) Working instructions for patient care; and l) Service continuity plan for Services in response to internal and external disasters. <u>Job-specific</u> m) Explanation of particular duties and functions; n) Explanation of the methods of assigning clinical care and the standards of clinical practice; o) Handover communication; p) Training in basic/advanced life support techniques; and q) Technology and equipment use including artificial intelligence, digital care and robotics.							
CRITERION 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	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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
in their current positions and future advancement.	3. Training schedule/calendar is in place; and						
	4. Training module.						
CRITERION 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.	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; and						
	4. Certificate of attendance.						
CRITERION 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.	1. Performance appraisal for staff is completed upon probationary period and as an annual exercise.						

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STANDARD 20.2.2 (NEW)

The Cleansing and Housekeeping Services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the Cleansing and Housekeeping Services staff, ensuring a safe and healthy work environment.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 20.2.2.1 (CORE)							
The Cleansing and Housekeeping Services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being. a) A health-promoting environment, e.g., stress management, burn out, staff engagement opportunities, workload monitoring, management of work life balance, healthy, lifestyle programmes e.g. Workplace Wellness Programs, Community-Based Health Initiatives; b) Staff shall be provided with appropriate supervision, support, and advice e.g., mentor mentee program; and c) There shall be clear procedures for the effective management of underperformance e.g., feedback on performance review or performance appraisal report.	1. The promotion of staff well-being may involve the following:						
		a. Evidence of a health promoting environment e.g., workplace wellness programme;					
		b. Evidence of proper supervision of staff; and					
		c. Evidence of staff appraisal programme with feedback on underperformance.					

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 20.2.2.2 (CORE)						
The Cleansing and Housekeeping Services shall establish a safe mechanism for Cleansing and Housekeeping Services staff to express grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety.	1. Cleansing and Housekeeping Services staff suggestions and grievance reporting and processing mechanisms are available; 2. The resolution of workplace issues may involve the following: a. Measures and evidence of Linen and Laundry Services staff protection including whistleblowers against violence, bullying, and harassment e.g., awareness campaigns, anonymous reporting channel, Whistleblower policy; and b. Documented policies and procedures for violence activation and Cleansing and Housekeeping Services staff protection.					
CRITERION 20.2.2.3 (NEW)						
A system shall be created to gather staff feedback about their workplace experience such as burnout which shall be analysed and used to make improvements that enhance the work environment, staff satisfaction, and organisation culture.	1. Staff feedback (e.g., minutes of sessions or staff satisfactions survey): a. Evidence of action or improvement taken.					
CRITERION 20.2.2.4 (NEW)						
The Cleansing and Housekeeping Services shall track sick leave and Cleansing and Housekeeping Services staff	1. Evidence that workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked					

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning	for trends and compared across departments. The results shall be used to create focused actions that improve staff well-being, solve problems, and help retain employees.						

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TOPIC 20.3
POLICIES AND PROCEDURES

STANDARD 20.3.1
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 Cleansing and Housekeeping Services and relevant regulations and statutory requirements.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 20.3.1.1 (CORE)							
There are written policies and procedures for the Cleansing and Housekeeping Services which are consistent with the overall policies of the Facility, regulatory requirements, current standard practices and Patients and Family Rights. These policies and procedures are signed, authorised and dated. The policies to categories the Facility areas into four (4) different levels of risk as recommended in MS 2757:2023 namely very high, high, moderate and low risk. The procedures to adopt the different elements, methods and frequencies of cleansing recommended in MS 2757:2023. There is a mechanism for and evidence of a periodic review at least once in every three years	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; and						
	4. The policies and procedures are endorsed and dated.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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; and						
	3. Documented cross departmental policies.						
CRITERION 20.3.1.3 (CORE)							
There is evidence of implementation and compliance with relevant policies and procedures.	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.						
CRITERION 20.3.1.4							
Copies of policies and procedures (MS 2757:2023), protocols, guidelines, relevant Acts, PHFS Act Chapter 9, Regulations, ByLaws and statutory requirements are accessible to staff.	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 20.3.1.5							
Policies and procedures for the Cleansing and Housekeeping Services shall include the following: a) Routine and special-purpose cleaning (daily cleaning vs terminal 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; and h) Safety and health aspects, e.g. use of personal protective equipment (PPE).	1. Policies and procedures on Cleansing and 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 et.						
	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; and						
	h. Segregation of solid waste, if applicable						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 20.3.1.6							
Storage areas comply with Safety Programmes and Fire Safety requirements as in the Environmental and Safety Services, Standard No.2.	1. Policy on handling and storage of chemicals as per regulatory requirement and standards i.e. Department of Occupational Safety and Health (DOSH) requirements; and						
	2. Dedicated chemical storage areas with good ventilation system, washing facilities and appropriate Personal Protective Equipment (PPE).						
CRITERION 20.3.1.7							
Current policies and procedures are communicated to all staff.	1. Training and briefing on the current policies and procedures/Minutes of meetings; and						
	2. Circulation list and acknowledgement.						

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TOPIC 20.4
FACILITIES AND EQUIPMENT

STANDARD 20.4.1
There are safe and adequate facilities and equipment to enable the Cleansing and Housekeeping Services to meet its goals and objectives and ensuring patient and staff safety.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Adequate and proper utilisation of space:						
	a. Adequate storage space for cleaning chemicals and equipments;						
	b. Dedicated routes for waste collection; and						
	c. Designated wash and drying areas for mop heads.						
	2. Appropriate type of equipment:						
	a. Adequate and appropriate PPE for housekeeping staff; and						
	b. Complete cleansing and housekeeping trolley including measured containers.						
	3. Easy access and clear exit routes;						
	4. Ventilated Janitors room; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	5. Appropriate staff change rooms with shower and lockers						
CRITERION 20.4.1.2							
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); and						
	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.						
CRITERION 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.	1. Planned Preventive Maintenance records such as schedule, stickers, etc.;						
	2. Calibration records;						
	3. Planned Replacement Programme where applicable;						
	4. Repair and maintenance records; and						
	5. Asset inventory/master list of equipment.						
CRITERION 20.4.1.4							
Where specialised equipment is used, there is evidence that only staff who are trained and	1. User training records;						
	2. Competency assessment record;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
authorised by the Facility operate such equipment.	1. Letter of authorization; and						
	2. List of staff trained and authorised to operate specialised equipment.						
CRITERION 20.4.1.5 (CORE)							
Solution, cleaning chemicals and hazardous substances shall be properly labeled and stored in safe places as per Safety Data Sheet (SDS) Proper dilutions of cleaning chemical to be adhered according to manufacturing recommendations.	1. SDS records;						
	2. Chemical master list; and						
	3. Chemical store with washing facilities and adequate ventilation.						
CRITERION 20.4.1.6 (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	4. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care.						

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TOPIC 20.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 20.5.1
The Head of Cleansing and Housekeeping Services shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Housekeeping Services.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 20.5.1.1							
There are periodical planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Housekeeping Services. The process includes: a) Planned activities; a) Data collection; b) Monitoring and evaluation of the performance; c) Action plan for improvement; d) Implementation of action plan; e) Re-evaluation for improvement; f) Risk Management Report ; g) Staff Safety report as per OSHA requirement; h) Usage of new cleaning technology to reduce manpower; and i) Innovation	1. Planned performance improvement activities include (a) to (j);						
	2. Records on performance improvement activities;						
	3. Minutes of performance improvement meetings;						
	4. Performance improvement studies; and						
	5. Records on innovation if available.						
CRITERION 20.5.1.2							
The Head of Cleansing and Housekeeping Services has assigned the responsibilities for planning, monitoring and managing safety and performance	1. Minutes of Meetings;						
	2. Letter of assignment of responsibilities; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
improvement to appropriate individual/personnel within the respective services.	3. Job description.						
CRITERION 20.5.1.3							
The Head of the Cleansing and 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.	1. System for incident reporting is in place, which include:						
	a. Training of staff;						
	b. Policy on incident reporting;						
	c. Methodology of incident reporting; and						
	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 and						
	8. Feedback given to staff regarding incident reporting.						
CRITERION 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	1. Specific performance indicators monitored;						
	2. Records on tracking and trending analysis; and						
	3. Remedial measures taken where appropriate.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
(Target: 80% with minimum score of 3) b) Facility user's satisfaction feedback **(Target: 80% satisfaction)** c) Cleaning turnaround < than 30 minutes between cases d) ICU/Isolation rooms/wards terminal cleaning **(Target: < 40 minutes after discharges)**							
CRITERION 20.5.1.5 (NEW)							
The Services participates in the Facility's safety culture assessment. The results are utilized by Service leadership to inform and guide efforts to improve the culture of safety within the Service.	1. Safety Culture Survey for staff.						
CRITERION 20.5.1.6							
Feedback on the results of safety and performance improvement activities are regularly communicated to the staff to promote transparency, shared learning, and active engagement in improvement initiatives.	1. Results on safety and performance improvement activities are accessible to staff through education sessions, meetings and digital communications.						
CRITERION 20.5.1.7							
Appropriate documentation of safety and performance improvement activities is kept and	1. Documentation on performance improvement activities and performance indicators; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
confidentiality of medical practitioners, staff and patients is preserved.	2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						
CRITERION 20.5.1.8 (CORE)							
There are safety and performance improvement activities that address staff safety of the outsourced service providers.	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; and						
	d. Biohazard waste disposal.						
	7. Medical check-up record;						
	8. Post exposure management and						
	9. Training module to include infection control such as standard precautions and outbreaks management.						

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ERVICE SUMMARY	
OVERALL RATING :	-
OVERALL RISK :	-

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SERVICE STANDARD 21 : LINEN AND LAUNDRY SERVICES

PREAMBLE

The Linen and Laundry Services include the process of managing, cleaning, sanitizing, storing and distributing linens and garments within the healthcare facility. The services may be done provided in house or contracted to a qualified external contractor meeting MSQH standards and criteria for Accreditation as stipulated under MS 2760: 2025 including standards for Prevention and Control of Infection involving the management of clean and soiled linen, starting from healthcare facilities to the laundry plant and vice versa.

TOPIC 21.1
ORGANISATION AND MANAGEMENT

STANDARD 21.1.1
The Linen and Laundry Services are organised and administered to provide a full range of clean, sanitize and distribution of linen and garment for the optimum care for patients according to the goals and objectives of the Facility.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 21.1.1.1							
Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Linen and Laundry 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.	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 and Laundry Services are measurable in line with the Facility statements available, endorsed and dated.						
	3. Evidence of planned reviews of the above statements (at least once in 3 years or in the event of any major changes)						
	4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc).						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.						
CRITERION 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; and d) Is revised when there is a major change in any of the following: i) Organisation; ii) Functions; iii) Reporting relationships; and iv) Staffing patterns	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; and						
	3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).						
CRITERION 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.	1. Minutes are accessible, disseminated and acknowledged by the staff;						
	2. Attendance list of members with adequate representation of the service;						
	3. Frequency of meetings as scheduled; and						
	4. Discussion and resolutions are implemented.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 21.1.1.4							
The Head of Linen and Laundry Services is involved in the planning, justification and management of the budget and resource utilisation of the services.	1. Minutes of Facility-wide management meeting;						
	2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service; and						
	3. Approved budget and resources.						
CRITERION 21.1.1.5							
The Head of Linen and Laundry Services is involved in the appointment and/OR assignment of staff.	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; and						
	5. Duty roster.						
CRITERION 21.1.1.6							
Appropriate statistics and records shall be maintained in relation to the provision of Linen and Laundry Services and used for managing the services and patient care.	1. Records are available for CRC provision but not limited to the following:						
	a. Workload/census;						
	b. Annual report;						
	c. Accident/incident reports to include RCA;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	d. Adequate staffing number and staff profile;						
	e. Staff training records;						
	f. Data on performance improvement activities, including performance indicators;						
	g. Linen inventory (min. 4 par level based on activities and frequency of delivery);						
	h. Customer feedback; and						
	i. Monthly laundry plant audit inspection records.						
CRITERION 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 as per PHFS (Chapter 10) and MS 2760:2025 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	1. Written agreement which includes (a) to (j) between the external service provider and the Facility is endorsed, signed and dated; and						
	2. Delivery and collection schedule.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
standards as stipulated under MS 2760:2025; c) provision of adequate numbers of appropriately qualified personnel to perform their duties including Head and staff of the Laundry Plant; 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 laundry plant site of the external service for washing, ironing, folding, storage and issuance of linen supplies; i) involvement of the external service provider in safety and performance improvement activities of the Facility, as appropriate; and j) comply with the appropriate MSQH Standards of Accreditation and MS 2760:2025 for Linen and Laundry Services which functions within the Facility.							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 21.1.1.8 (CORE)							
Where services are provided by an external source, the Person In Charge (PIC) of the Facility shall appoint persons to supervise, monitor and provide technical input to the Linen and Laundry Services. The Head of Laundry Plant shall be qualified by education, training, and experience.	1. Appointment/assignment letter of liaison officer with terms of reference; 2. Job description; and 3. Description of duties and responsibilities.						
CRITERION 21.1.1.9 (NEW)							
The Head of Services shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	1. Documented and approved BCP for unanticipated situations; 2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment. 3. Clear actions and staff responsibilities during disruption; 4. Record of drills or tests, with follow-up actions, if conducted; and 5. Review of Risk Register.						

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TOPIC 21.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD 21.2.1
The Linen and Laundry Services shall be directed and adequately staffed with appropriately qualified and trained personnel to achieve the goals and objectives of the services.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 21.2.1.1							
The Head and staff of the Linen and Laundry Services shall be individuals qualified by education, training, and experience to commensurate with the requirements of the various positions.	1. Records on qualification and experience of Head of Service and staff related to linen services;						
	2. Appointment/assignment letters; and						
	3. Training and competency records.						
CRITERION 21.2.1.2							
The authority, responsibilities and accountabilities of the Head of Linen and Laundry Services are clearly delineated and documented.	1. Appointment /assignment letter for Head of Service; and						
	2. Description of duties and responsibilities.						
CRITERION 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 at the facility and the laundry plant.	1. Number of staff and qualification should commensurate with workload;						
	2. Staffing patter;						
	3. Duty roster; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	4. Census on workload.						
CRITERION 21.2.1.4							
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.	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 authorisation granted where applicable (e.g., operating specialised equipment); and						
	4. The job description is acknowledged by the staff and signed by the Head of Service and dated.						
CRITERION 21.2.1.5							
Personnel records on training, staff development, leave and others are maintained for every	1. Staff personal records include:						
	a. Curriculum Vitae (CV);						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
staff at the facility and the laundry plant. **Note:** Staff personal record may be kept in Human Resource Department as per Facility policy	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; and						
	g. Immunisation record.						
CRITERION 21.2.1.6 (CORE)							
Provision of vaccination programmes for all staff exposed to sharps injury and biological hazards.	1. Vaccination programme; and						
	2. Vaccination records.						
CRITERION 21.2.1.7 (CORE)							
There is a structured orientation programme for all newly appointed, contracted and outsourced staff to the Services that include but not limited to the following: General a) Vision and mission of the Facility; b) Organisation chart and reporting structure of the Facility; c) Environment and facility safety policies and	1. Policy requiring all new staff to attend a structured orientation programme;						
	2. There is Services orientation programme with relevant topics not limited to topics covered from (a) to (q); and						
	3. Attendance list.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
procedures including sustainability practices; d) Infection control policies and procedures; e) Policies for performance management, patient safety (IPSG/MPSG) and risk management; f) Ethical practices and code of conduct including medicolegal awareness; g) Management of aggression, violence and harassment; h) Patient and family rights. <u>Services</u> i) Goals, objectives and organisational structure of Services; j) Policies and procedures relevant to Services; k) Working instructions for patient care; and l) Service continuity plan for services in response to internal and external disasters. <u>Job-specific</u> m) Explanation of particular duties and functions; n) Explanation of the methods of assigning clinical care and the standards of clinical practice; o) Handover communication; p) Training in basic/advanced life support techniques;							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
q) Technology and equipment use including artificial intelligence, digital care and robotics							
CRITERION 21.2.1.8							
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.	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; and						
	4. Training module to include but not limited to infection control such as standard precautions and outbreaks management.						
CRITERION 21.2.1.9							
There are continuing education activities for staff to pursue professional interests and to prepare for current and future changes in practice.	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; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	4. Certificate of attendance.						
CRITERION 21.2.1.10							
Staff receive evaluations of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.	1. Performance appraisal for staff is completed upon probationary period and as an annual exercise.						

STANDARD 21.2.2 (NEW)

The Linen and Laundry Services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the Linen and Laundry Services staff, ensuring a safe and healthy work environment.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 21.2.2.1 (CORE) (NEW)							
The Linen and Laundry Services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being. a) A health-promoting environment, e.g., stress management, burnout, staff engagement opportunities, workload monitoring, management of work life balance, healthy, lifestyle programmes e.g. Workplace Wellness Programs, Community-Based Health Initiatives; b) Staff shall be provided with appropriate supervision,	1. The promotion of staff well-being may involve the following:						
	a. Evidence of a health promoting environment e.g., workplace wellness programme;						
	b. Evidence of proper supervision of staff; and						
	c. Evidence of staff appraisal programme with feedback on underperformance.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
support, and advice e.g., mentor mentee program; and c) There shall be clear procedures for the effective management of underperformance e.g., feedback on performance review or performance appraisal report.							
CRITERION 21.2.2.2 (CORE) (NEW)							
The Linen and Laundry Services shall establish a safe mechanism for Linen and Laundry Services staff to express grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety.	1. Linen and Laundry Services staff suggestions and grievance reporting and processing mechanisms are available;						
	2. The resolution of workplace issues may involve the following:						
	a. Measures and evidence of Linen and Laundry Services staff protection including whistleblowers against violence, bullying, and harassment e.g., awareness campaigns, anonymous reporting channel, Whistleblower policy; and						
	b. Documented policies and procedures for violence activation and Linen and Laundry Services staff protection.						
CRITERION 21.2.2.3 (NEW)							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
A system shall be created to gather staff feedback about their workplace experience such as burnout which shall be analysed and used to make improvements that enhance the work environment, staff satisfaction, and organisation culture.	1. Staff feedback (e.g., minutes of sessions or staff satisfactions survey)						
	a. Evidence of action or improvement taken.						
CRITERION 21.2.2.4 (NEW)							
The Linen and Laundry Services shall track sick leave and Linen and Laundry Services staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning	1. Workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments; and						
	2. The results shall be used to create focused actions that improve staff well-being, solve problems, and help retain employees.						

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TOPIC 21.3
POLICIES AND PROCEDURES

STANDARD 21.3.1
DEVELOPMENT, DERIVATION AND DOCUMENTATION
There are documented policies and procedures that reflect current knowledge and practice of Linen and Laundry Services and they are consistent with the goals and objectives of the Linen and Laundry Services and relevant regulations and statutory requirements.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 21.3.1.1 (CORE)							
There are written policies and procedures for the Linen and Laundry Services which are consistent with the overall policies of the Facility and Laundry Plant, regulatory requirements, current standard practices and Patients and Family Rights. 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.	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; and						
	4. The policies and procedures are endorsed and dated.						
CRITERION 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.	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; and						
	3. Documented cross departmental policies.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 21.3.1.3							
Current policies and procedures are communicated to all staff.	1. Training and briefing on the current policies and procedures/Minutes of meetings; and						
	2. Circulation list and acknowledgement.						
CRITERION 21.3.1.4 (CORE)							
There is evidence of compliance with relevant policies and procedures.	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.						
CRITERION 21.3.1.5							
Copies of policies and procedures, protocols, guidelines, relevant Acts, PHFS Act (Chapter 10), MS 2760:2025 Regulations, ByLaws and statutory requirements are accessible to staff.	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible for staff reference.						

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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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 21.3.2.1 (CORE)							
The patient shall not be in soiled linen under any circumstances.	1. Policy on Linen supply; and						
	2. Patients have clean linen as evidenced on-site.						
CRITERION 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. Soil linen collected from nursery should be segregated in separate bag to be label as “Nursery”	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; and						
	4. Soil linen collected from nursery should be segregated in separate bag to be label as “Nursery”.						
CRITERION 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.	1. Policy and procedure on handling infectious linen;						
	2. Use of colour coded linen bag for different types of linen hospital wide; and						
	3. Use of alginate bag for infectious linen as evidenced on site.						
CRITERION 21.3.2.4 (CORE)							

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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); and c) Physical appearance and condition of linen.	1. Policies and Procedures on Linen and Laundry Services that address but not limited to items (a) to (c) are available.						
CRITERION 21.3.2.5 (CORE)							
Trolleys transporting soiled linen bags and storage areas for soiled linen are cleaned and covered according to agreed schedule	1. Policy and procedure on handling containers for transporting.						
	2. Schedule on cleaning linen transporting containers.						
	3. Records on cleaning containers used for transporting soiled linen.						
CRITERION 21.3.2.6 (CORE)							
Clean linen is transported and stored separately from soiled linen.	1. Policy and procedure 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; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	4. Dedicated clean linen storage area.						
CRITERION 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. Ventilation requirement for soiled linen and clean linen storage facility to be complied based on air movement from clean to dirty flow.	1. Dedicated area for handling and processing of soiled linen;						
	2. Compliance to policies and procedures on in-house processing of linen;						
	3. Clean linen storage area to be positive pressure; and						
	4. Soiled linen storage area to be negative pressure.						
CRITERION 21.3.2.8							
Smoking is prohibited in areas for handling linen.	1. 'No Smoking' signage displayed; and						
	2. Policy on smoking prohibition.						
CRITERION 21.3.2.9							
Surfaces and overhead areas in the laundry and central linen storage area are cleaned as to agreed schedule.	1. Cleaning schedule for laundry and storage area surfaces including overhead areas; and						
	2. Clean surfaces/environment in laundry and linen storage area evidenced upon onsite inspection.						
CRITERION 21.3.2.10							
The laundry plant area and the facility central linen storage area	1. As built drawing of laundry/design meets relevant standards;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
are planned and equipped to prevent the dissemination of contaminants, and there is good exhaust ventilation with airflow from clean to soiled areas.	2. Work process prevents dissemination of contaminants; and						
	3. Ventilation with airflow from clean to soiled areas.						
CRITERION 21.3.2.11							
To minimise the risk of cross infection, hand hygiene facilities are readily available in the clean and soiled linen areas at laundry plant area and the facility. Staff are required to put on appropriate personal protective equipment in the soiled area.	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						

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TOPIC 21.4
FACILITIES AND EQUIPMENT

STANDARD 21.4.1
There are safe and adequate facilities and equipment to enable the Linen and Laundry Services to meet its goals and objectives and ensuring patient and staff safety.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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 at the facility and laundry plant.	1. Adequate and proper utilisation of space:						
	a. Separate entrance for clean and soiled linen; and						
	b. Adequate linen storage space.						
	2. Appropriate type of equipment:						
	a. Appropriate personal protective equipment available for Linen and Laundry Services staff.						
	3. Easy access and clear exit routes.						
	4. Appropriate staff change rooms with showers and lockers.						
CRITERION 21.4.1.2							
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); and						
	2. Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM) and MS 2760:2025, etc as evidence of						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	compliance to the relevant standards and Acts.						
CRITERION 21.4.1.3 (CORE)							
There is evidence that the facility and the laundry plant has a comprehensive maintenance programme such as planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.	1. Planned Preventive Maintenance records such as schedule, stickers, etc.;						
	2. Calibration records;						
	3. Planned Replacement Programme where applicable;						
	4. Repair and maintenance records; and						
	5. Asset inventory/master list of equipment.						
CRITERION 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.	1. User training records (laundry plant);						
	2. Competency assessment record;						
	3. Letter of authorisation; and						
	4. List of staff trained and authorised to operate specialised equipment.						
CRITERION 21.4.1.5							
There are appropriate arrangements made for the disposal of waste water and chemical detergent from laundry plant to sewage system.	1. Drainage drawing on disposal of waste water and chemical detergent from laundry plant to sewage system; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	2. Appropriateness of disposal of waste water and chemical detergent as observed onsite.						
CRITERION 21.4.1.6 (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care.						

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TOPIC 21.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 21.5.1
The Head of Linen and Laundry Services shall ensure the provision of quality performance with staff involvement in the continuous safety and quality improvement activities of the Linen Services at the Facility and the Laundry Plant.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 21.5.1.1							
There are periodical planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Linen and Laundry Services. The process includes: d) Planned activities; a) Data collection; b) Monitoring and evaluation of the performance; c) Action plan for improvement; d) Implementation of action plan; e) Re-evaluation for improvement; f) Risk Management Report ; g) Staff Safety as per OSHA requirement; h) Microbiological test to be conducted on linen and delivery transport; and i) Innovation.	1. Planned performance improvement activities include (a) to (j);						
	2. Records on performance improvement activities;						
	3. Minutes of performance improvement meetings;						
	4. Performance improvement studies; and						
	5. Records on innovation if available.						
CRITERION 21.5.1.2							
The Head of Linen and Laundry Services has assigned the responsibilities for planning, monitoring and managing safety	1. Minutes of meetings;						
	2. Letter of assignment of responsibilities; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
and performance improvement to appropriate individual/personnel within the respective services.	3. Job description.						
CRITERION 21.5.1.3							
The Head of the Linen and Laundry 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.	1. System for incident reporting is in place, which include:						
	a. Training of staff;						
	b. Policy on incident reporting;						
	c. Methodology of incident reporting; and						
	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; and						
	8. Feedback given to staff regarding incident reporting.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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%)** c) Percentage of incidents reported monthly that have had Root Cause Analysis (RCA) done and action taken to prevent recurrence **(Target: 100%)** d) Facility user satisfaction survey **(Target: 80% satisfaction)**	1. Specific performance indicators monitored.						
	2. Records on tracking and trending analysis.						
	3. Remedial measures taken where appropriate.						
CRITERION 21.5.1.5 (NEW)							
The Services participates in the Facility's safety culture assessment. The results are utilized by Service leadership to inform and guide efforts to improve the culture of safety within the Service.	1. Safety Culture Survey for staff.						
CRITERION 21.5.1.6							
Feedback on the results of safety and performance improvement activities are regularly communicated to the staff to promote transparency, shared learning, and active engagement in improvement initiatives.	1. Results on safety and performance improvement activities are accessible to staff through education sessions, meetings and digital communications.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 21.5.1.7							
Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.	1. Documentation on performance improvement activities and performance indicators.						
	2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						

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SERVICE SUMMARY	
OVERALL RATING :	-
OVERALL RISK :	-

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SERVICE STANDARD 22 : FOOD SERVICES

PREAMBLE

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.

Components of such services may be provided by one department or through separate entities and contracts:

a) Inpatient Food Services; and

b) *Cafeteria/Food Court/Food Outlets/ Vending Machines.*

TOPIC 22.1
ORGANISATION AND MANAGEMENT

STANDARD 22.1.1

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. 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.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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	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 are measurable in line with the Facility statements are available, endorsed and dated;						
	3. Evidence of planned reviews of the above statements (at least once in						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
revised as required accordingly and communicated to all staff.	3 years or in the event of any major changes);						
	4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc); and						
	5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.						
CRITERION 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; and d) Is revised when there is a major change in any of the following: i) Organisation; ii) Functions; iii) Reporting relationships; and iv) Staffing patterns	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; and						
	3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).						
CRITERION 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	1. Minutes are accessible, disseminated and acknowledged by the staff;						
	2. Attendance list of members with adequate representation of the service.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.	3. Frequency of meetings as scheduled; and						
	4. Discussion and resolutions are implemented.						
CRITERION 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.	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; and						
	4. Letter of Appointment of Head of Food Services.						
CRITERION 22.1.1.5							
The Head of Food Services is involved in the appointment and/or assignment of staff.	1. Records on staff interview (if applicable);						
	2. Assignment letter of Head of Service;						
	3. Job description;						
	4. Records on staff deployment; and						
	5. Duty roster.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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. Information on the number of meals provided (normal and therapeutic diets) and unit costs is kept.	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; and						
	g. Data on performance improvement activities, including performance indicators.						
CRITERION 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: a) Good Manufacturing Practice (GMP) certification; b) Hazard Analysis Critical Control Point (HACCP); and c) Halal certification.	1. GMP certification;						
	2. HACCP certification;						
	3. Cycle/Choice Menus; and						
	4. Halal certification.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 22.1.1.8 (NEW)							
Menu Engineering and Planning Committee (Dietetic And Food service staff) shall be involved in the following aspects of food services to patients: a) Formulation of menus and recipes; and b) Continuous training and education for food services staff.	1. Minutes of Menu Committee meeting;						
	2. Cycle/Choice Menus; and						
	3. Training records.						
CRITERION 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	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 (if included in the terms of the contract); and						
	5. HACCP certification (if included in the terms of the contract).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and h) Space, facilities and equipment are provided by the Facility.							
CRITERION 22.1.1.9 (NEW)							
The Head of Services shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	1. Documented and approved BCP for unanticipated situations;						
	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment.						
	3. Clear actions and staff responsibilities during disruption;						
	4. Record of drills or tests, with follow-up actions, if conducted; and						
	5. Review of Risk Register.						

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TOPIC 22.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD 22.2.1
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.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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	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; and						
	4. Training and competency records.						
CRITERION 22.2.1.2 (CORE)							
The Person In Change (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.	1. Appointment/approval letter of visiting dietitian; and						
	2. Attendance and record of visits by visiting dietitian.						
CRITERION 22.2.1.3 (NEW)							
The authority, responsibilities and accountabilities of the Head	1. Appointment/assignment letter for Head of Service; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
of Food Services are clearly delineated and documented.	2. Description of duties and responsibilities.						
CRITERION 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.	1. Number of staff and qualification commensurate with workload;						
	2. Staffing pattern and review of staffing needs;						
	3. Duty roster; and						
	4. Census and statistics.						
CRITERION 22.2.1.5							
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;	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; and						
	4. The job description is acknowledged by the staff and signed by the Head of Service and dated.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
v) Staffing patterns; and vi) Statutory Regulations.							
CRITERION 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.	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.						
CRITERION 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	1. Policy requiring all new staff to attend a structured orientation programme;						
	2. Records on structured orientation programme;						
	3. Orientation Training Module; and						
	4. List of attendance.						
CRITERION 22.2.1.8							
There is evidence of training needs assessment and staff	1. Training needs assessment is carried out and gaps identified;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
development plan which provides the knowledge and skills required for staff to maintain competency in their current positions and future advancement.	2. A staff development plan based on training needs assessment is available;						
	3. Training schedule/calendar is in place; and						
	4. Training module.						
CRITERION 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.	1. Continuing education activities schedule;						
	2. Contents of training programme;						
	3. Training records on continuing education activities are kept and maintained for each staff; and						
	4. Attendance list/ certificate of attendance/degree.						
CRITERION 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.	1. Performance appraisal for staff is completed upon probationary period and as an annual exercise.						
CRITERION 22.2.1.11 (CORE)							
All food handlers shall undergo medical screening, immunisation and Food Handler Training as required by relevant statutory requirements.	1. Pre-employment medical checkup record;						
	2. Immunisation record (Typhoid); and						
	3. Food Handlers Certificate.						

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Standard 22.2.2 (NEW)

The food services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the food staff, ensuring a safe and healthy work environment.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 22.2.2.1 (CORE)							
The food services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being.	1. Health-promoting activities, e.g., stress management						
	2. Mentor mentee program for related staff						
	3. Feedback from poor performance review						
CRITERION 22.2.2.2 (CORE)							
The food services shall establish a safe mechanism for food services staff to express grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety.	1. Food services staff suggestions, grievance reporting and processing mechanisms are available;						
	2. The resolution of workplace issues may involve the following:						
	a. Policy and procedures for the protection of the whistleblower;						
	b. Anonymous reports received from staff;						
	c. Staff orientation modules to include violence and whistleblower protection, bullying, and harassment;						
	d. Awareness campaigns to promote safe workplace culture; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	e. Training and adherence to documented policies and procedures for violence activation and food services staff protection.						
CRITERION 22.2.2.3 (NEW)							
A system shall be created to gather staff feedback about their workplace experience such as burnout which shall be analysed and used to make improvements that enhance the work environment, staff satisfaction, and organisation culture.	1. Food services staff feedback (e.g., minutes of sessions or food services staff satisfactions survey):						
	a. Evidence of action or improvement taken.						
CRITERION 22.2.2.4 (NEW)							
The food services shall track sick leave and dietetic staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning	1. Workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments; and						
	2. The results shall be used to create focused actions that improve staff well-being, solve problems, and help retain employees.						

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TOPIC 22.3
POLICIES AND PROCEDURES

STANDARD 22.3.1
DEVELOPMENT, DERIVATION AND DOCUMENTATION

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.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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, current standard practices and Patients and Family Rights. 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.	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; and						
	4. The policies and procedures are endorsed and dated.						
CRITERION 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.	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; and						

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.	3. Documented cross departmental policies.						
CRITERION 22.3.1.3							
Current policies and procedures are communicated to all staff.	1. Training and briefing on the current policies and procedures/Minutes of meetings; and						
	2. Circulation list and acknowledgement.						
CRITERION 22.3.1.4 (CORE)							
There is evidence of compliance with policies and procedures.	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; and						
	d. Practices in line with established policies and procedures.						
CRITERION 22.3.1.5							
Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, ByLaws and statutory requirements are accessible to staff.	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference; and						
	2. Copy of guidelines on current "Hospital Catering" by Ministry of						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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	Health or other recognised bodies is available for reference.						
CRITERION 22.3.1.6							
Fire precautions, disaster plans and safety procedures shall be documented and followed.	1. Manuals/Protocols on safety include:						
	a. Internal fire drill;						
	b. Disaster plan;						
	c. Evacuation plan; and						
	d. Safety procedures in the kitchen.						
CRITERION 22.3.1.7							
Stock control, ordering and stock taking arrangements shall be in place to promote effective management of the Food Services and deter pilfering and theft.	1. Stock control card / system; and						
	2. Stock taking records (monthly or quarterly).						
CRITERION 22.3.1.8							
Documentation of policies for storage and handling of food shall be evident.	1. Standard operating procedures for storage and handling of food;						
	2. Standard operating procedures for monitoring of temperatures; and						
	3. Cleaning schedule for storage facilities.						
CRITERION 22.3.1.9							
	1. Policies and procedures on handling cooked and raw food;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Food ready for consumption and raw food shall be stored and handled separately.	2. Compliance to procedures as evidenced by work process; and						
	3. Designated storage and handling areas.						
CRITERION 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.	1. Staff training records on bulk preparation and holding;						
	2. Standard operating procedures for bulk preparation; and						
	3. Compliance to procedures as evidenced by work process.						
CRITERION 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.	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 4;						
	5. HACCP certification; and						
	6. HALAL certification.						
CRITERION 22.3.1.12							
There shall be designated staff to deliver and serve the food to the	1. Cross departmental policy; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
patients supervised and monitored by the nursing staff.	2. Compliance to policy as evidenced by work process.						
CRITERION 22.3.1.13							
There is an appropriate documented procedure to ensure safe provision of meals to infectious patients.	1. Documented policy on safe provision of meals for infectious patients; and						
	2. Evidence of compliance upon onsite inspection.						
CRITERION 22.3.1.14							
Documented procedures shall be evident for the cleaning of all equipment.	1. Documented policy and procedures for cleaning of all equipment; and						
	2. Records on cleaning of equipment.						
CRITERION 22.3.1.15							
Procedures for machine and hand dishwashing shall be documented and available.	1. Documented policy and procedures for machine and hand washing; and						
	2. Compliance to procedures for machine and hand washing as evidenced upon on site inspection.						
CRITERION 22.3.1.16							
Garbage shall be held in covered containers and removed from the Food Services area daily as per schedule.	1. Documented policy on waste disposal; and						
	2. Compliance with the policy on waste disposal.						
CRITERION 22.3.1.17							
There is a proper procedure for the disposal of food refuse.	1. Documented policy and procedures for disposal of food refuse; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	2. Compliance with policy and procedures for disposal of food refuse.						
CRITERION 22.3.1.18							
There is a continuing programme on pest and vermin control.	1. Policy and procedures on pest and vermin control; and						
	2. Inspection and treatment records on pest and vermin control.						
CRITERION 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.	1. Report or Certificate by Health Authority; and						
	2. Monitoring records.						
CRITERION 22.3.1.20							
All food services staff shall comply with good hygienic and safety practices including personal hygiene and clothing while on duty.	1. Policy and procedures on appropriate clothing of staff/food handlers;						
	2. Compliance to policies and procedures on hand washing technique; and						
	3. Representation of the Food Services in Hospital Infection and Antibiotic Control Committee/Team.						
CRITERION 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	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).						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and d) With an acute respiratory infection.	1. Work instructions for staff to comply during illnesses/conditions.						

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TOPIC 22.4
FACILITIES AND EQUIPMENT

STANDARD 22.4.1
Appropriate and adequate physical layout, mechanical, electrical facilities, and equipment shall be available for the efficient operations of the Food Services.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 22.4.1.1 (CORE)							
The layout of areas for Food Services shall allow for the following: a) Receiving of food stocks; b) Storage of food ensuring adequate separation of dry ration from perishable and adequate segregation of perishable by type; c) Food handling prior to cooking with separate process areas for meat, fish and vegetables to prevent cross contamination; d) Separate areas for preparation of salad, pastries and confectionaries; m e) Preparation of food including cooking or reconstitution; f) Separate area for preparation and handling of therapeutic diet as well as special menus to suit religious and cultural preferences; g) Holding of prepared food; h) Tray line for plating of food;	1. Kitchen design and layout plan shall address all items in (a) to (n) and evidenced upon on-site inspection; 2. Clear signage and labelling of designated areas; and 3. Work process as prescribed in the layout plan.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
i) Distribution of food or meals; j) Dishwashing and scullery activities; k) Storage for crockery, cutlery and other items; l) Waste disposal; m) Adequate hand washing facilities for staff, separate from those utilised for food preparation; and n) Staff rest and changing areas should be outside any food preparation area.							
CRITERION 22.4.1.2							
Floors, walls, and ceilings finishes shall be easily cleaned, non-skid, impervious and kept in good repair.	1. Floors, walls and ceilings comply with standard materials and kept in good repair as evidenced upon inspection; and						
	2. Regular cleaning and maintenance reports.						
CRITERION 22.4.1.3							
Lighting shall be adequate and appropriate to provide safe work environment.	1. Adequate lighting; electrical lighting is covered;						
	2. Report on regular inspection of lightings						
CRITERION 22.4.1.4							
Appropriate ventilation, temperature and humidity control shall be available to provide	1. Temperature and humidity monitoring records;						
	2. Kitchen hood /air extractor maintenance reports; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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comfortable working condition and promote cleanliness.	3. Comfortable working condition as evidenced upon onsite inspection.						
CRITERION 22.4.1.5							
There is evidence of compliance with fire safety requirements.	1. Appropriate fire suppression system;						
	2. Evacuation plan;						
	3. Fire safety inspection records;						
	4. Maintenance report;						
	5. Reports on fire drill; and						
	6. Extension of Public Address (PA) system to the kitchen.						
CRITERION 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.	1. Temperature monitoring records and trending;						
	2. Standard operating procedures on types of food storage facilities; and						
	3. Storage practices comply with relevant standards.						
CRITERION 22.4.1.7							
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); and						
	2. Certification of equipment from certified bodies, e.g. Standards and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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	Industrial Research Institute of Malaysia (SIRIM), etc as evidence of compliance to the relevant standards and Acts.						
CRITERION 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.	1. Planned Preventive Maintenance records (schedule, stickers) including calibration and grease trap inspection records;						
	2. Planned Replacement Programme where applicable;						
	3. Complaint records; and						
	4. Asset inventory.						
CRITERION 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.	1. User training records;						
	2. Competency assessment record if applicable; and						
	3. List of staff trained and authorised to operate specialised equipment.						
CRITERION 22.4.1.10 (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care.						

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TOPIC 22.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 22.5.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 22.5.1.1 (CORE)							
There are periodical 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; and g) Innovation	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; and						
	5. Records on innovation if available.						
CRITERION 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.	1. Minutes of meetings;						
	2. Letter of assignment of responsibilities; and						
	3. Job description.						
CRITERION 22.5.1.3							
The Head of the Food Services shall ensure that the staff are trained and complete incident reports which are promptly	1. System for incident reporting is in place, which include:						
	a. Training of staff;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.	b. Policy on incident reporting;						
	c. Methodology of incident reporting; and						
	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; and						
	8. Feedback given to staff regarding incident reporting.						
CRITERION 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	1. Specific performance indicators monitored;						
	2. Records on tracking and trending analysis; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
to patients (Target: sentinel event); and c) Client food satisfaction survey (Target: above 90%).	3. Remedial measures taken where appropriate.						
CRITERION 22.5.1.5							
Feedback on results of safety and performance improvement activities are regularly communicated to the staff to promote transparency, shared learning, and active engagement in improvement initiatives.	1. Results on safety and performance improvement activities are accessible to staff through education sessions, meetings and digital communications.						
CRITERION 22.5.1.6							
Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.	1. Documentation on performance improvement activities and performance indicators; and						
	2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						

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TOPIC 22.6
SPECIAL REQUIREMENTS

STANDARD 22.6.1
CAFETERIA SERVICES/FOOD COURT/FOOD OUTLETS/VENDING MACHINES
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 22.6.2 (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	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; and						
	d. Certification ie Kafetaria Sihat / BESS.						
CRITERION 22.6.3							
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.	1. Valid licence from local authority;						
	2. Immunisation record (Typhoid); and						
	3. Food Handlers Training Certificate.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 22.6.4							
The Head of the Food Services shall oversee the operations of the Cafeteria Services/Food Court/Food Outlets/Vending Machines.	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; and						
	3. Monitoring schedule and reports.						
CRITERION 22.6.1.4							
Sufficient numbers of trained personnel and support staff are employed to allow for the services to meet its documented purposes.	1. List of employee;						
	2. Duty roster; and						
	3. Staff training certificate.						
CRITERION 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.	1. Orientation programme schedule and contents; and						
	2. Attendance list.						
CRITERION 22.6.1.6							
There is clear evidence of appropriate quality assurance mechanism and adherence to	1. Records and results of food sampling and inspection; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
standards and regulations on Food Quality as stipulated by the local authority, including microbiological testing on food samples.	2. Food sampling schedule.						
CRITERION 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; and d) With an acute respiratory infection.	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; and						
	3. Deployment records.						

STANDARD 22.6.2
CAFETERIA SERVICES/FOOD COURT/FOOD OUTLETS/VENDING MACHINES
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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 22.6.2.1							
There are written policies and procedures for Cafeteria Services/Food Court/Food Outlets/Vending Machines (in outsourced services terms of	1. Written policies and procedures for cafeteria services/food court/food outlets/Vending Machines						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
contract) that are consistent with the overall policies of the Facility.							
CRITERION 22.6.2.2							
New and revised policies and procedures are communicated to members of Cafeteria Services/Food Court/Food Outlets management.	1. Circulation list and acknowledgement on policies and procedures;						
	2. Briefing and attendance records; and						
	3. Minutes of meetings.						
CRITERION 22.6.2.3							
There is evidence of compliance with policies and procedures, including Patients and Family Rights.	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.						
	2. Adherence to relevant Patients and Family Rights standards (refer to Standard 6).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 22.6.2.4							
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.	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference; and						
	2. Copies of relevant documents including guidelines on “Hospital Catering” by Ministry of Health or other recognised bodies is available for references.						
CRITERION 22.6.2.5							
Fire precautions, disaster plans and safety procedures are documented and followed.	1. Fire detection and suppression system;						
	2. Evacuation plan;						
	3. Fire safety inspection records;						
	4. Maintenance report; and						
	5. Reports on Fire drill.						
CRITERION 22.6.2.6							
Planned preventive and corrective maintenance programmes for equipment and records shall be in place.	1. Planned preventive maintenance records; and						
	2. Corrective maintenance records.						
CRITERION 22.6.2.7							
Documentation of policies and procedures for storage and handling of food shall be evident.	1. Policies and procedures for storage and handling of food.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 22.6.2.8							
Cooked food and raw food shall be stored and handled separately.	1. Cafeteria layout with designated food storage and handling areas; and						
	2. Compliance to procedures as evidenced by work processes onsite.						
CRITERION 22.6.2.9							
Garbage shall be held in covered containers and removed from the cafeteria daily as per schedule.	1. Policy and procedure on waste disposal; and						
	2. Garbage disposal schedule.						
CRITERION 22.6.2.10							
A clear procedure shall be established and documented as regards to the disposal of food refuse.	1. Policy and procedures for disposal of food refuse; and						
	2. Food refuse disposal schedule.						
CRITERION 22.6.2.11							
There shall be a continuing programme of pest and vermin control.	3. Policy and procedures on pest and vermin control; and						
	4. Inspection and treatment records on pest and vermin control.						
CRITERION 22.6.2.12 (CORE)							
There is evidence of inspection and certification by the Health Authority at least annually and the rating should be 75% and above.	1. Certificate by Health Authority; and						
	2. Monitoring records.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 22.6.2.13							
Appropriate clean, protective clothing shall be worn by all staff and this clothing shall be changed daily and as required.	1. Policy and procedures on appropriate clothing of food handlers evidenced upon onsite inspection;						
	2. Records on consumables on Personal Protective Equipment; and						
	3. Audit record on practice.						
CRITERION 22.6.2.14							
All food services staff shall comply with good hygienic practices while on duty.	1. Instructions on handwashing technique at worksite; and						
	2. Records on audit on hand washing technique.						

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STANDARD 22.6.3
CAFETERIA SERVICES/FOOD COURT/FOOD OUTLETS/VENDING MACHINES
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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 22.6.3.1							
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; and l) Adequate hand washing facilities for staff, separate	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; and						
	3. Work process comply with layout plan as evidenced upon onsite inspection.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
from those utilised for food preparation in the main kitchen area.							
CRITERION 22.6.3.2							
Floors, walls, and ceilings finishes shall be easily cleaned, non-skid, impervious and kept in good repair.	1. Floors, walls and ceilings comply with standard materials and kept in good repair as evidenced upon inspection; and						
	2. Regular cleaning and maintenance reports.						
CRITERION 22.6.3.3							
Appropriate lighting to allow safe work environment shall be available.	1. Adequate lighting; electrical lightings are covered;						
	2. Report on regular inspection of lightings; and						
	3. Electrical lightings should be covered.						
CRITERION 22.6.3.4							
Appropriate ventilation, temperature and humidity to provide comfortable working conditions and promote cleanliness..	1. Comfortable environment for staff/public as evidenced upon onsite inspection;						
	2. Monitoring of temperature records, e.g. Data logger/manual recording; and						
	3. Maintenance of hood/extractor report.						
CRITERION 22.6.3.5							
There is evidence that the Cafeteria Services/Food	1. Fire detection and suppression system;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Court/Food Outlets/Vending Machines has complied with fire safety requirements.	2. Evacuation plan;						
	3. Fire safety inspection records;						
	4. Maintenance report;						
	5. Reports on Fire drill; and						
	6. Training records.						
CRITERION 22.6.3.6							
Refrigeration and storage of food in dry storage, refrigerated storage and in freezers shall comply with appropriate health regulations and standards of good practice.	1. Temperature monitoring records on freezer/refrigerator and trending; and						
	2. Compliance to standard operating procedures as evidenced onsite.						
CRITERION 22.6.3.7							
There is documented evidence that equipment complies with relevant standards and current statutory requirements.	1. Testing, commissioning and calibration records (certificates or stickers); and						
	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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 22.6.3.8							
There is evidence that the facilities and equipment are maintained in good working order and subject to ongoing planned preventive maintenance and calibration.	1. Planned preventive maintenance records; and						
	2. Calibration records.						
CRITERION 22.6.3.9							
Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.	1. User training records;						
	2. Competency assessment record;						
	3. Letter of authorisation; and						
	4. List of staff trained and authorised to operate specialised equipment.						

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STANDARD 22.6.4
CAFETERIA SERVICES/FOOD COURT/FOOD OUTLETS/VENDING MACHINES
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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 22.6.4.1							
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.	1. Records on complaints and feedback; and						
	2. Records on safety and performance improvement activities i.e. food safety initiatives, menu improvements, etc.						
CRITERION 22.6.4.2							
Appropriate documentation of safety and performance improvement activities is kept, e.g. client satisfaction survey.	1. Records on client food satisfaction survey.						

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SERVICE SUMMARY	
OVERALL RATING :	-
OVERALL RISK :	-

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SERVICE STANDARD 23 : FORENSIC MEDICINE SERVICES

PREAMBLE

Forensic Medicine Services cover forensic pathology, clinical forensic medicine and forensic medicine 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.

TOPIC 23.1
ORGANISATION AND MANAGEMENT

STANDARD 23.1.1
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 forensic medicine services provided by the Facility.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 23.1.1.1							
Vision, Mission, and statements of values of the Facility are accessible. Goals and objectives that suit the scope of Forensic Medicine Services are clearly documented and measurable, indicating safety and quality services being delivered. These reflect the roles and aspirations of the services 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 Forensic Medicine Services are measurable in line with the Facility statements available, endorsed and dated;						
	3. Evidence of planned reviews of the above statements (at least once in 3 years or in the event of any major changes);						
	4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc.); and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.						
CRITERION 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 and staff of the Forensic Medicine Services. b) Is accessible to all staff and clients; c) Includes off-site services if applicable; and d) Is revised when there is a major change in any of the following: i) Organisation; ii) Functions; iii) Reporting relationships; and 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 Forensic Medicine Services, consultants / specialists, medical practitioners and staff of the Forensic Medicine Services;						
	2. Organisation chart of the services endorsed, dated and accessible; and						
	3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).						
CRITERION 23.1.1.3							
The Forensic Medicine Services are organised to reflect the role of the Facility in the activities of the services, which are readily available and include the following: a) Perform professional activities in accordance with	1. Written documentation on the scope of the Forensic Medicine Services to include but not limited to (a) to (g).						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
the ethical standards of the profession; b) Access to information (if applicable) regarding the 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 health care professionals, law enforcement and judiciary agencies, and other relevant stake holders on matters related to the services provided; e) Provision of services on a 24-hour basis (if applicable); 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.							
CRITERION 23.1.1.4							
Regular staff meetings are held between the Head of Services and staff with sufficient regularity to discuss issues and matters pertaining to the operations of Forensic Medicine Services.	1. Minutes are accessible, disseminated and acknowledged by the staff; 2. Attendance list of members with adequate representation of the service;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the services, and implemented.	3. Frequency of meetings as scheduled; and						
	4. Discussion and resolutions are implemented.						
CRITERION 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.	1. Minutes of Facility-wide management meeting;						
	2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service; and						
	3. Approved budget and resources.						
CRITERION 23.1.1.6							
The Head of Forensic Medicine Services is involved in the appointment and/or assignment of staff.	1. Records on staff interview (if applicable);						
	2. Appointment/assignment letter of Head of Services;						
	3. Job description of Head of Forensic Medicine Services;						
	4. Records on staff deployment; and						
	5. Duty roster.						
CRITERION 23.1.1.7							
There is collaboration between the staff of Forensic Medicine Services and other relevant	1. Documented evidence of interaction with the relevant agency/services of the Facility. *Examples: scan						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
agencies in matters relating to Forensic Medicine activities.	meeting, under-5, maternal mortality etc.						
CRITERION 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.	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; and						
	f. Data on performance improvement activities, including performance indicators.						
CRITERION 23.1.1.9 (NEW)							
The Head of Services shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	1. Documented and approved BCP for unanticipated situations;						
	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment.						
	3. Clear actions and staff responsibilities during disruption;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	4. Record of drills or tests, with follow-up actions, if conducted; and						
	5. Review of Risk Register.						

STANDARD 23.1.2

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. 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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 23.1.2.1							
The off-site forensic laboratory shall fulfil the legal requirements as follows: h) Stipulated by the provision of Criminal Procedure Code or other relevant directives, national policies and guidelines; and i) Preservation of the chain of evidence.	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; and						
	3. The medical-based laboratory services conform to all relevant approved standards.						
CRITERION 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	1. Verification on-site during survey on compliance to (a) and (b).						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
applicable to forensic and medico-legal practices; and b) Preservation of the chain of evidence.							

TOPIC 23.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD 23.2.1
The Forensic Medicine Services are supervised by a qualified and competent forensic medicine specialist / forensic pathologist. The day-to-day operations of the services may be delegated to a suitably qualified, trained and experienced staff.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 23.2.1.1							
The direction and supervision of the services shall be by a Forensic Medicine Specialist / Forensic Pathologist. The Forensic Medicine Specialist / Forensic Pathologist is competent in the specialty and actively practicing as evidenced by: a) Being on regular duty in the Forensic Medicine Services; and b) Participating in continuing medical education activities.	1. The Forensic Medicine Specialist / Forensic Pathologist is registered with the National Specialist Register (NSR);						
	2. Appointment/assignment letter;						
	3. Job description; and						
	4. Documentation of participation in continuing medical education.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 23.2.1.2 (CORE)							
The Head of Forensic Medicine Services and staff shall be individuals qualified by education, training and experience to practice forensic medicine to commensurate with the requirements of the various positions.	1. All staff of the Forensic Medicine Services shall have a valid professional Annual Practicing Certificate (APC) or its equivalent in accordance with regularity and licensing requirements;						
	2. List of staff with post basic or advance certification in forensic disciplines;						
	3. Experience of staff meets the demand of their positions; and						
	4. Assignment according to staff specialty.						
CRITERION 23.2.1.3							
The authority, responsibilities, and accountabilities of the Head of Forensic Medicine Services are clearly delineated and documented.	1. Appointment/assignment letter for Head of Forensic Medicine Services; and						
	2. Description of duties and responsibilities.						
CRITERION 23.2.1.4							
Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the needs of the services.	1. Number of staff and qualification should commensurate with workload;						
	2. Staffing pattern;						
	3. Duty roster; and						
	4. Census and statistics.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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; and 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; and						
	4. The job description is acknowledged by the staff and signed by the Head of Forensic Medicine Services and dated.						
CRITERION 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.	1. Staff personal records include:						
	a. Staff biodata;						
	b. Qualification and experience;						
	c. Evidence of current registration;						
	d. Training record;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	e. Competency record and privileging;						
	f. Leave record;						
	g. Confidentiality agreement;						
	h. Health records;						
	a) Immunisation status.						
CRITERION 23.2.1.7 (CORE)							
There is a structured orientation programme for all newly appointed, contracted and outsourced staff to the Services that include but not limited to the following: <u>General</u> a) Vision and mission of the Facility; b) Organisation chart and reporting structure of the Facility; c) Environment and facility safety policies and procedures including sustainability practices; d) Infection control policies and procedures; e) Policies for performance management, patient safety (IPSG/MPSG) and risk management; f) Ethical practices and code of conduct including medicolegal awareness;	1. Policy requiring all new staff to attend a structured orientation programme;						
	2. There is Services orientation programme with relevant topics not limited to topics covered from (a) to (q); and						
	3. Attendance list.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
g) Management of aggression, violence and harassment; and h) Patient and family rights. <u>Services</u> i) Goals, objectives and organisational structure of Services; j) Policies and procedures relevant to Services; k) Working instructions for patient care; and l) Service continuity plan for Services in response to internal and external disasters. <u>Job-specific</u> m) Explanation of particular duties and functions; n) Explanation of the methods of assigning clinical care and the standards of clinical practice; o) Handover communication; p) Training in basic/advanced life support techniques; and q) Technology and equipment use including artificial intelligence, digital care and robotics							
CRITERION 23.2.1.8							
Staff are closely supervised and given appropriate instructions to carry out their duties.	1. Job description and privileging certificate are available.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 23.2.1.9							
There are evidence of training needs assessment and a staff development plan that provides the knowledge and skills required for staff to maintain competency in their current positions and for future advancement.	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; and						
	4. Training module.						
CRITERION 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.	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; and						
	4. Certificate of attendance.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Performance appraisals for staff including medical practitioners are completed upon probationary period and as an annual exercise.						
CRITERION 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.	1. Records of participation in training and education; and						
	2. A copy of Memorandum of Understanding (MOU) in the Hospital.						
CRITERION 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.	1. Records of participation of other health personnel in forensic services in training and education; and						
	2. A copy of Memorandum of Understanding (MOU) in the Hospital.						

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STANDARD 23.2.2 (NEW)

The Forensic Medicine Services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the Forensic Medicine Services staff, ensuring a safe and healthy work environment.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 23.2.2.1 (CORE) (NEW)							
The Services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being. a) A health-promoting environment, e.g., stress management, burn out, staff engagement opportunities, workload monitoring, management of work life balance, healthy, lifestyle programmes e.g. Workplace Wellness Programs, Community-Based Health Initiatives; b) Staff shall be provided with appropriate supervision, support, and advice e.g., mentor mentee program; and c) There shall be clear procedures for the effective management of underperformance e.g., feedback on performance review or performance appraisal report.	1. The promotion of staff well-being may involve the following:						
		a. Evidence of a health promoting environment e.g., workplace wellness programme;					
		b. Evidence of proper supervision of staff; and					
		c. Evidence of staff appraisal programme with feedback on underperformance.					

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 23.2.2.2 (CORE) (NEW)							
The Forensic Medicine Services shall establish a safe mechanism for Forensic Medicine Services staff to express grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety.	1. The Forensic Medicine Services shall establish a safe mechanism for Forensic Medicine Services staff to express grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety; and						
	2. The resolution of workplace issues may involve the following:						
	a. Measures and evidence of Forensic Medicine Services staff protection including whistleblowers against violence, bullying, and harassment e.g., awareness campaigns, anonymous reporting channel, Whistleblower policy; and						
	b. Documented policies and procedures for violence activation and Forensic Medicine Services staff protection.						
CRITERION 23.2.2.3 (NEW)							
A system shall be created to gather Services staff feedback about their workplace experience such as burnout which shall be analysed and used to make improvements that enhance the	1. Staff feedback (e.g., minutes of sessions or staff satisfactions survey):						
	a. Evidence of action or improvement taken.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
work environment, staff satisfaction, and organisation culture.							
CRITERION 23.2.2.4 (NEW)							
The Forensic Medicine Services shall track sick leave and Forensic Medicine Services staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning	1. Workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments; and						
	2. The results shall be used to create focused actions that improve staff well-being, solve problems, and help retain employees.						

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TOPIC 23.3
POLICIES AND PROCEDURES

STANDARD 23.3.1
DEVELOPMENT, DERIVATION AND DOCUMENTATION
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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, current standard practices and Patients and Family Rights. 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.	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; and						
	4. The policies and procedures are endorsed and dated.						
CRITERION 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 practiced in	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; and						
	3. Documented cross departmental policies.						

DISTRIBUTION

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
developing relevant policies and procedures where applicable.							
CRITERION 23.3.1.3							
Current policies and procedures are communicated to all staff.	1. Training and briefing on the current policies and procedures/Minutes of meetings; and						
	2. Circulation list and acknowledgement.						
CRITERION 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.	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.						
CRITERION 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 /coroner) who are authorised to order a forensic post-mortem examination; b) Written orders (e.g. Polis 61 Form /PDRM (S) 61 for a forensic post-mortem examination; c) Identification of the deceased or body part by full name*/identification document number*/identity card*/passport*/police report	1. Documented policies and procedures including but not limited to items (a) to (f). * not applicable to unknown bodies.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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 f) Types of specimens collected at post-mortem which are to be submitted for histopathological, microbiological/virological, toxicological, and other relevant investigations. *not applicable to unknown bodies.							
CRITERION 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 the chain of evidence shall be maintained throughout the process of specimen handling.	1. Standard operating procedures/work instruction/guidelines on specimen handling;						
	2. Specimen dispatch record book; and						
	3. Specimen handling form.						
CRITERION 23.3.1.7 (CORE)							
Complete records and documentation of body management shall be maintained: a) Registration of bodies received;	1. Complete records and documentation of body management include (a) to (e).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.							
CRITERION 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 by the ward staff 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; and g) Procedures of release of unclaimed bodies	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.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Safety procedures and manuals on hazards and safety precautions are available; and						
	2. Verification on practice in Standard Precautions and Safety Guidelines on-site.						
CRITERION 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.	1. Assignment letter of Safety Officer; and						
	2. Job description.						

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TOPIC 23.4
FACILITIES AND EQUIPMENT

STANDARD 23.4.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 23.4.1.1							
The mortuary shall be accessible from an outside entrance and following a designated route of the Facility.	1. Mortuary is accessible from an outside entrance of the Facility; and						
	2. Conveyance of body to the Mortuary is via a designated route and entrance.						
CRITERION 23.4.1.2							
Appropriate transport for transferring bodies to the mortuary that commensurate with the dignity and respect accorded to the deceased.	1. Proper covered body trolley and appropriate transport are available to transfer the bodies.						
CRITERION 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;	1. Appropriate areas for reception of bodies and storage that address (a) to (e).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
d) The temperature of the body freezer $4^{o}C \pm 2$ 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.							
CRITERION 23.4.1.4 (CORE)							
There are appropriate areas for the 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) The 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 odors in the work area where appropriate.	1. Appropriate areas for post-mortem suite which include items (a) to (f).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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 that are suitably located; and c) Adequate and appropriate lighting.	1. Suitable, adequate and safe provision of:						
	a. Air conditioning;						
	b. Lighting;						
	c. Power supply;						
	d. Water supply; and						
	e. Effluent drainage.						
CRITERION 23.4.1.6							
There are designated areas for reception and the handling of decomposed bodies/high risk cases where applicable.	1. Designated areas for reception and the handling of decomposed bodies/high risk cases.						
CRITERION 23.4.1.7							
There are designated areas for body cleansing/preparation, body viewing, bereavement, performing religious rites and releasing of bodies.	1. Designated areas for:						
	a. Body cleansing/preparation;						
	b. Body viewing;						
	c. Bereavement;						
	d. Performing religious rites (where appropriate); and						
	e. Release of bodies.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Staff facilities are available as follows:						
	a. Changing room;						
	b. Shower						
	c. Locker facilities; and						
	d. Storage for protective clothing/gear.						
CRITERION 23.4.1.9							
There are adequate and appropriate data processing, retrieval, and communication facilities.	1. Documentation on death registration.						
	a. Communication facilities.						
CRITERION 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 authorized operate such equipment/chemical.	1. User training records;						
	2. Competency assessment record*;						
	3. List of staff trained and authorised to operate specialised equipment; and						
	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.)						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 23.4.1.11							
All equipment shall meet current safety standards, e.g. electrical safety code based on Testing and Commissioning (T&C) documentation.	1. T&C documentation is available for equipment.						
CRITERION 23.4.1.12							
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); and						
	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.						
CRITERION 23.4.1.13							
Adequate and designated storage area for consumables and chemicals.	1. Storage area for consumables and chemicals;						
	2. Inventory list for consumables and chemicals; and						
	3. Material Safety Data Sheet (MSDS) documents on usage, storage and disposal of hazardous chemicals are available on- site.						
CRITERION 23.4.1.14 (CORE)							
Planned preventive maintenance of equipment, instrument and facility are in place.	1. Asset inventory;						
	2. Complaint records;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	3. Logbook and Planned Preventive Maintenance (PPM) records are available;						
	4. Calibration records are available; and						
	5. Replacement of equipment (Beyond Economic Repair) if applicable.						
CRITERION 23.4.1.15							
There is evidence of general cleanliness in the Forensic Medicine Services.	1. Good housekeeping is evidenced on-site.						
CRITERION 23.4.1.16							
There are proper facilities for the disposal of biohazard material as either effluent or containerized material.	1. Proper disposal of biohazard material as containerized material or effluent according to regulations evidenced on-site.						
CRITERION 23.4.1.17 (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promotes environmentally sustainable care.						

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TOPIC 23.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 23.5.1
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 Forensic Medicine Services.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 23.5.1.1							
There are periodical 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; and g) Innovation.	1. Planned performance improvement activities include (a) to (g);						
	2. Records on performance improvement activities;						
	3. Minutes of performance improvement meetings;						
	4. Performance improvement studies; and						
	5. Records on innovation if available.						
CRITERION 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.	1. Minutes of Meetings;						
	2. Letter of assignment of responsibilities; and						
	3. Job description.						
CRITERION 23.5.1.3							
The Head of the Forensic Medicine Services shall ensure that the staff	1. System for incident reporting is in place, which include:						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.	a. Training of staff;						
	b. Policy on incident reporting;						
	c. Methodology of incident reporting; and						
	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; and						
	8. Feedback given to staff regarding incident reporting.						
CRITERION 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%); and b) Percentage of completion of post-mortem reports for non-complicated cases from the	1. Specific performance indicators monitored;						
	2. Records on tracking and trending analysis; and						
	3. Remedial measures taken where appropriate.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
date of post-mortem within twelve (12) weeks. (Target: ≥85%) **Notes:** Non-complicated cases refer to accidents, suicides and natural deaths which are routine police cases subjected to forensic post-mortem examination.							
CRITERION 23.4.5.1.5 (NEW)							
The Services participates in the Facility's safety culture assessment. The results are utilized by Service leadership to inform and guide efforts to improve the culture of safety within the Service.	1. Safety Culture Survey for staff						
CRITERION 23.4.5.1.6							
Feedback on the results of safety and performance improvement activities is regularly communicated to the staff to promote transparency, shared learning, and active engagement in improvement initiatives.	1. Results of safety and performance improvement activities are accessible to staff through education sessions, meetings and digital communications.						
CRITERION 23.5.1.7							
Appropriate documentation of safety and performance improvement activities is kept, and confidentiality of medical practitioners, staff and deceased is preserved.	1. Documentation on performance improvement activities and performance indicators; and						
	2. Policy statement on anonymity on deceased and providers involved in performance improvement activities.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 23.5.1.8							
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.	1. Evidence of participation of Internal Quality Control (IQC) and External Quality Control (EQA)/Interlaboratory Comparison; and						
	2. Performance review/discussion of IQC and EQA/ Interlaboratory Comparison.						
CRITERION 23.5.1.9							
Forensic Medicine Specialist shall participate in audit activities with other clinical specialists.	1. Records of audit activities.						

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SERVICE SUMMARY	
OVERALL RATING :	-
OVERALL RISK :	-

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SERVICE STANDARD 23A : MORTUARY SERVICES

PREAMBLE

Mortuary Services shall be provided within the Facility. Where there is no resident Forensic Pathologist, 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:

a) Body reception,
b) Body storage,
c) Body preparation/release area,
d) Area for body viewing,
e) Bereavement/counselling room, and
f) Post-mortem suite (where applicable).

TOPIC 23A.1
ORGANISATION AND MANAGEMENT

STANDARD 23A.1.1
The Mortuary Services are organised and administered to provide quality services appropriate to the level of mortuary services provided by the Facility.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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 services and the needs of the community. These statements are monitored, reviewed and revised as required	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 are measurable in line with the Facility statements available, endorsed and dated;						
	3. Evidence of planned reviews of the above statements (at least once in						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
accordingly and communicated to all staff.	3 years or in the event of any major changes;						
	4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc); and						
	5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.						
CRITERION 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; and d) Is revised when there is a major change in any of the following: i) Organisation; ii) Functions; iii) Reporting relationships; and 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 Mortuary Services, medical practitioners and staff of the Mortuary Services;						
	2. Organisation chart of the services endorsed, dated and accessible; and						
	3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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 health care professionals, law enforcement and judiciary agencies, and other relevant stake holders on matters related to the services provided; d) Provision of services on a 24-hour basis (if applicable).	1. Written documentation for the Mortuary Services include but not limited to items (a) to (d).						
CRITERION 23A.1.1.4							
Regular staff meetings are held between the Head of Mortuary Services 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	1. Minutes are accessible, disseminated and acknowledged by the staff;						
	2. Attendance list of members with adequate representation of the service;						
	3. Frequency of meetings as scheduled; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
accessible, communicated to all staff of the services and implemented.	4. Discussion and resolutions are implemented.						
CRITERION 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.	1. Minutes of Facility-wide management meeting;						
	2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service; and						
	3. Approved budget and resources.						
CRITERION 23A.1.1.6							
The Head of Mortuary Services is involved in the appointment and/or assignment of staff.	1. Records on staff interview (if applicable);						
	2. Appointment/assignment letter of Head of Mortuary Services;						
	3. Job description of Head of Mortuary Services;						
	4. Records on staff deployment; and						
	5. Duty roster.						
CRITERION 23A.1.1.7							
There is collaboration between the staff of Mortuary Services with other relevant agencies in	1. Documented evidence of interaction with the relevant agencies of the Facility. *Examples: document of						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
matters relating to mortuary activities.	body management with public health, local authority etc.						
CRITERION 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.	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; and						
	f. Data on performance improvement activities, including performance indicators.						
CRITERION 23A.1.1.9 (NEW)							
The Head of Services shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	1. Documented and approved BCP for unanticipated situations;						
	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment.						
	3. Clear actions and staff responsibilities during disruption;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	4. Record of drills or tests, with follow-up actions, if conducted; and						
	5. Review of Risk Register.						

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TOPIC 23A.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD 23A.2.1
The Mortuary Services are supervised by a suitably qualified, trained and competent medical practitioner and assisted by relevant categories of staff.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 23A.2.1.1 (CORE)							
The Head of Mortuary Services and staff 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/ assistant medical officer / local facility's head; and b) There is evidence that the staff have some training or experience in the processes governing the mortuary.	1. Appointment/assignment letter;						
	2. Certification; and						
	3. Training and competency records						
CRITERION 23A.2.1.2							
The authority, responsibilities and accountabilities of the Head of Mortuary Services are clearly delineated and documented.	1. Appointment/assignment letter for Head of Services; and						
	2. Description of duties and responsibilities.						
CRITERION 23A.2.1.3							
Sufficient numbers of personnel and support staff with appropriate	1. Number of staff and qualification should commensurate with workload;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
qualifications are employed to meet the need of the services	2. Staffing pattern;						
	3. Duty roster; and						
	4. Census and statistics.						
CRITERION 23A.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; and vi) Statutory Regulations. e) Administrative and mortuary 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; and						
	4. The job description is acknowledged by the staff and signed by the Head of Mortuary Services and dated.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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	1. Staff personal records include:						
	a. Curricular Vitae (CV);						
	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; and						
	i. Immunisation status.						
CRITERION 23A.2.1.6							
Staff are closely supervised and given appropriate instruction to carry out their duties.	1. Job description;						
	2. Privileging certificate; and						
	3. Competency/supervision records.						
CRITERION 23A.2.1.7 (CORE)							
There is a structured orientation programme for all newly appointed, contracted and	1. Policy requiring all new staff to attend a structured orientation programme;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
outsourced staff to the Services that include but not limited to the following: General a) Vision and mission of the Facility; b) Organisation chart and reporting structure of the Facility; c) Environment and facility safety policies and procedures including sustainability practices; d) Infection control policies and procedures; e) Policies for performance management, patient safety (IPSG/MPSG) and risk management; f) Ethical practices and code of conduct including medicolegal awareness; g) Management of aggression, violence and harassment; and h) Patient and family rights. Services i) Goals, objectives and organisational structure of Services; j) Policies and procedures relevant to Services; k) Working instructions for patient care; and l) Service continuity plan for Services in response to	2. There is Services orientation programme with relevant topics not limited to topics covered from (a) to (q); and						
	3. Attendance list.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
internal and external disasters. Job-specific m) Explanation of particular duties and functions; n) Explanation of the methods of assigning clinical care and the standards of clinical practice; o) Handover communication; p) Training in basic/advanced life support techniques; and q) Technology and equipment use including artificial intelligence, digital care and robotics.							
CRITERION 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.	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; and						
	4. Training module.						
CRITERION 23A.2.1.9							
There are continuing education activities for staff to pursue professional interests and to	1. Training calendar includes in-house/external courses/ workshop/conferences;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
prepare for current and future changes in practice.	2. Contents of training programme;						
	3. Training records on continuing education activities are kept and maintained for each staff including training in life support; and						
	4. Certificate of attendance.						
CRITERION 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.	5. Performance appraisal for staff including medical practitioners is completed upon probationary period and as an annual exercise.						
CRITERION 23A.2.1.11							
The Mortuary Services shall provide continuing education activities for other health professional staff and relevant agencies to keep them informed of advances in forensic related field.	6. Records on participation of other health personnel in training and education in Mortuary Services.						

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STANDARD 23A.2.2 (NEW)
The Mortuary Services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the Mortuary Services staff, ensuring a safe and healthy work environment.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 23A.2.2.1 (CORE) (NEW)							
The Services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being. a) A health-promoting environment, e.g., stress management, burnout, staff engagement opportunities, workload monitoring, management of work life balance, healthy, lifestyle programmes e.g. Workplace Wellness Programs, Community-Based Health Initiatives; b) Staff shall be provided with appropriate supervision, support, and advice e.g., mentor mentee program; and c) There shall be clear procedures for the effective management of underperformance e.g., feedback on performance review or performance appraisal report.	1. The promotion of staff well-being may involve the following:						
		a. Evidence of a health promoting environment e.g., workplace wellness programme.					
		b. Evidence of proper supervision of staff.					
		c. Evidence of staff appraisal programme with feedback on underperformance.					
CRITERION 23A.2.2.2 (CORE) (NEW)							
The Mortuary Services shall establish a safe mechanism for Mortuary Services staff to express grievances, provide	1. Mortuary Services staff suggestions and grievance reporting and processing mechanisms are available; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety.	2. The resolution of workplace issues may involve the following:						
	a. Measures and evidence of Mortuary Services staff protection including whistleblowers against violence, bullying, and harassment e.g., awareness campaigns, anonymous reporting channel, Whistleblower policy; and						
	b. Documented policies and procedures for violence activation and Mortuary Services staff protection.						
CRITERION 23A.2.2.3 (NEW)							
A system shall be created to gather staff feedback about their workplace experience such as burnout which shall be analysed and used to make improvements that enhance the work environment, staff satisfaction, and organisation culture.	1. Staff feedback (e.g., minutes of sessions or staff satisfactions survey):						
	a. Evidence of action or improvement taken.						
CRITERION 23A.2.2.4 (NEW)							
The Mortuary Services shall track sick leave and Mortuary Services staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning	1. Workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments; and						
	2. The results shall be used to create focused actions that improve staff well-being, solve problems, and help retain employees.						

TOPIC 23A.3
POLICIES AND PROCEDURES

STANDARD 23A.3.1
DEVELOPMENT, DERIVATION AND DOCUMENTATION

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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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, current standard practices and Patients and Family Rights. 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.	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; and						
	4. The policies and procedures are endorsed and dated.						
CRITERION 23A.3.1.2							
Policies and procedures are developed by a committee in collaboration with staff, medical practitioners in accordance with the National Forensic Service Guidelines.	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; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.	3. Documented cross departmental policies.						
CRITERION 23A.3.1.3							
Current policies and procedures are communicated to all staff.	1. Training and briefing on the current policies and procedures/Minutes of meetings; and						
	2. Circulation list and acknowledgement.						
CRITERION 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.	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.						
CRITERION 23A.3.1.5							
There are policies and procedures relating to all post-mortem examinations (where applicable): a) Persons (police or magistrate /coroner) who are authorised to order a forensic post-mortem examination; b) Written orders (e.g. Polis 61 form /pdrm (s) 61 for a medico-legal forensic post-mortem examination; c) Identification of the deceased or body part by full name*/identification document number*/identity card*/passport*/police report	1. Documented policies and procedures including but not limited to items (a) to (f).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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 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							
CRITERION 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	1. Standard operating procedures/work instruction/guidelines on specimen handling						
	2. Specimen dispatch record book						
	3. Specimen handling form						
CRITERION 23A.3.1.7 (CORE)							
Complete records and documentation of body management shall be maintained where applicable :	1. Complete records and documentation of body management include (a) to (e).						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and e) All movement of records or reports out of the forensic services.							
CRITERION 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 by the ward staff 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;	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;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
f) Procedures for releasing the deceased to the next of kin; and g) Procedures of release of unclaimed bodies.	d. practices in line with established policies and procedures.						
CRITERION 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	1. Safety procedures and manuals on hazards and safety precautions are available; and						
	2. Verification on practice on compliance to Standard Precautions and Safety Guidelines on-site.						
CRITERION 23A.3.1.10							
Mortuary Services staff shall be assigned as the safety officer to monitor safety in the mortuary and observance of Code of Safe Practice.	1. Assignment letter of Safety Officer; and						
	2. Job description.						

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TOPIC 23A.4
FACILITIES AND EQUIPMENT

STANDARD 23A.4.1
Appropriate, adequate and safe facilities and equipment are available to enable deceased organ and tissue donation and promotion meets its objectives and goals.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 23A.4.1.1							
The mortuary shall be accessible from an outside entrance and following a designated route of the Facility.	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.						
CRITERION 23A.4.1.2							
Appropriate transport for transferring bodies to the mortuary that commensurate with the dignity and respect accorded to the deceased.	1. Proper covered body trolley and appropriate transport are available to transfer the bodies.						
CRITERION 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 $4^{o}C \pm 2$ shall be	1. Appropriate areas for reception of bodies and storage that address items (a) to (e).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
maintained, monitored and documented; e) There are adequate space, facilities and equipment for the administrative, professional, and technical functions of the Mortuary Services.							
CRITERION 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; a) The post-mortem room is clean and has adequate space, ventilation and lighting; b) There are adequate facilities for performing post-mortem examination, recording of findings, specimen handling and storage; c) The post-mortem equipment is appropriate, adequate and is properly maintained; d) Post-mortem table is of a suitable design with proper facilities for the disposal of effluent into the sewage system to ensure safety; e) There is adequate ventilation with extraction for fumes and odours in the work area where appropriate.	1. Appropriate areas for post-mortem suites which include (a) to (f).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Suitable, adequate and safe provision of:						
	a. Air conditioning;						
	b. Lighting						
	c. Power supply						
	d. Water supply						
	e. Effluent drainage						
CRITERION 23A.4.1.6							
There are designated areas for reception and the handling of decomposed bodies/high risk cases where:	1. Designated areas for reception and the handling of decomposed bodies/high risk cases.						
CRITERION 23A.4.1.7							
There are designated areas for body cleansing/preparation, body viewing, bereavement, performing religious rites and release of bodies	1. Designated areas for:						
	a. Body cleansing/preparation,						
	b. Body viewing,						
	c. Bereavement,						
	d. Performing religious rites; and						
	e. Release of bodies.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Staff facilities are available as follows:						
	a. Changing room;						
	b. Shower;						
	c. Locker facilities; and						
	d. Storage for protective clothing /gear.						
CRITERION 23A.4.1.9							
There are adequate and appropriate data processing, retrieval, and communication facilities.	1. Documentation on death registration; and						
	2. Communication facilities.						
CRITERION 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	1. User training records;						
	2. Competency assessment record*;						
	3. List of staff trained and authorised to operate specialised equipment; and						
	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,						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	evidence management, chain of custody, mortuary management, crime scene etc.)						
CRITERION 23A.4.1.11							
All equipment shall meet current safety standards, e.g. electrical safety code based on Testing & Commissioning (T&C) documentation.	1. T&C documentation is available for equipment.						
	a. Effluent drainage.						
CRITERION 23A.4.1.12							
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); and						
	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.						
CRITERION 23A.4.1.13							
Adequate and designated storage area for consumables and chemicals.	1. Storage area for consumables and chemicals; and						
	2. Inventory list for consumables and chemicals.						
CRITERION 23A.4.1.14 (CORE)							
Where applicable, planned preventive maintenance of equipment, instrument and facility are in place.	1. Asset inventory;						
	2. Complaint records;						
	3. Logbook and Planned Preventive Maintenance (PPM) records are available;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	4. Calibration records are available; and						
	5. Replacement of equipment (Beyond Economic Repair) if applicable.						
CRITERION 23A.4.1.15							
There is evidence of general cleanliness in the Mortuary Services.	1. Good housekeeping is evidenced.						
CRITERION 23A.4.1.16							
There are proper facilities for the disposal of biohazard material as either effluent or containerised material.	1. Proper disposal of biohazard material as containerised material or effluent according to regulations evidenced onsite; and						
	2. Material Safety Data Sheet (MSDS) documents on usage, storage and disposal of hazardous chemicals are available on-site.						
CRITERION 23A.4.1.17 (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care.						

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TOPIC 23A.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 23A.5.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 23A.5.1.1							
There are periodical 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; and g) Innovation.	1. Planned performance improvement activities include (a) to (g);						
	2. Records on performance improvement activities;						
	3. Minutes of performance improvement meetings;						
	4. Performance improvement studies; and						
	5. Records on innovation if available.						
CRITERION 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.	1. Minutes of meetings;						
	2. Letter of assignment of responsibilities; and						
	3. Job description.						
CRITERION 23A.5.1.3							
The Head of Mortuary Services shall ensure that the staff are	1. System for incident reporting is in place, which include:						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.	a. Training of staff;						
	b. Policy on incident reporting;						
	c. Methodology of incident reporting; and						
	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; and						
	8. Feedback given to staff regarding incident reporting.						
CRITERION 23A.5.1.4 (CORE)							
	1. Specific performance indicators monitored;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
There is tracking and trending of specific performance indicators not limited to 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%) **Explanations:** Non-complicated cases refer to accidents, suicide and natural deaths which are routine police cases subjected to forensic post-mortem examination that do not require further laboratory investigations to determine the cause of death.	2. Records on tracking and trending analysis; and						
	3. Remedial measures taken where appropriate.						
CRITERION 23A.5.1.5 (NEW)							
The Services participates in the Facility's safety culture assessment. The results are utilized by Service leadership to inform and guide efforts to improve the culture of safety within the Service.	1. Safety Culture Survey for staff.						
CRITERION 23A.5.1.6							
Feedback on the results of safety and performance improvement activities is regularly communicated to the staff to promote transparency, shared learning, and active engagement in improvement initiatives.	1. Results of safety and performance improvement activities are accessible to staff through education sessions, meetings and digital communications.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 23A.5.1.7							
Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and deceased is preserved.	1. Documentation on performance improvement activities and performance indicators; and						
	2. Policy statement on anonymity on deceased and providers involved in performance improvement activities.						
CRITERION 23A.5.1.8 (CORE)							
Mortuary staff shall participate in audit activities with other departments.	1. Records on audit activities; and						
	2. Remedial measures taken where appropriate.						

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SERVICE SUMMARY	
OVERALL RATING :	-
OVERALL RISK :	-

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SERVICE STANDARD 24: STANDARDS FOR GENERAL APPLICATION

PREAMBLE

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.

TOPIC 24.1
ORGANISATION AND MANAGEMENT

STANDARD 24.1.1

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.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 24.1.1.1 (CORE)							
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.	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 are measurable in line with the Facility statements available, endorsed and dated;						
	3. Evidence of planned reviews of the above statements (at least once in 3 years or in the event of any major changes);						
	4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc.); and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.						
CRITERION 24.1.1.2							
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; and d) Is revised when there is a major change in any of the following: i) Organisation; ii) Functions; iii) Reporting relationships; and iv) Staffing patterns.	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).						
CRITERION 24.1.1.3 (CORE)							
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	1. Minutes are accessible, disseminated and acknowledged by the staff;						
	2. Attendance list of members with adequate representation of the service;						
	3. Frequency of meetings as scheduled; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
staff of the service and implemented.	4. Discussion and resolutions are implemented.						
CRITERION 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.	1. Minutes of Facility-wide management meeting;						
	2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service; and						
	3. Approved budget and resources.						
CRITERION 24.1.1.5							
The Head of Service is involved in the appointment and/OR assignment of staff.	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; and						
	6. Records on evaluation of vendor's performance.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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; and						
	f. Data on performance improvement activities, including performance indicators						
CRITERION 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.	1. Notation in the patient's medical record that cares has been given;						
	2. Response to care is recorded; and						
	3. Records are signed, dated, and designation stated.						
CRITERION 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	1. Written agreement which include (a) to (i) between the external service provider and the Facility is endorsed, signed and dated.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and i) Comply with the appropriate MSQH Standards of Accreditation for that part of the service which functions within the Facility.							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 17D.1.1.8 (NEW)							
The Head of Services shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	1. Documented and approved BCP for unanticipated situations;						
	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment.						
	3. Clear actions and staff responsibilities during disruption;						
	4. Record of drills or tests, with follow-up actions, if conducted; and						
	5. Review of Risk Register.						

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TOPIC 24.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD 24.2.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 24.2.1.1 (CORE)							
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.	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; and						
	4. Training and competency records.						
CRITERION 24.2.1.2							
The authority, responsibilities and accountabilities of the Head of Services are clearly delineated and documented.	1. Appointment/assignment letter for Head of Service; and						
	2. Description of duties and responsibilities.						
CRITERION 24.2.1.3 (CORE)							
Sufficient numbers of personnel and support staff with appropriate	1. Number of staff and qualification should commensurate with workload;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
qualifications are employed to meet the need of the services.	2. Staffing pattern;						
	3. Duty roster; and						
	4. Census and statistics.						
CRITERION 24.2.1.4 (CORE)							
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; and 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; and 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; and						
	4. The job description is acknowledged by the staff and signed by the Head of Service and dated.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 24.2.1.5							
Personnel records on training, staff development, leave and others are maintained for every staff. **Note:** Staff personal records may be kept in Human Resource Department as per hospital policy.	1. Staff personal records include:						
	a. Staff biodata;						
	b. Qualification and experience;						
	c. Evidence of current registration;						
	d. Competency record and privileging;						
	e. Leave record; and						
	f. Confidentiality agreement.						
CRITERION 24.2.1.6							
There is a structured orientation programme for all newly appointed, contracted and outsourced staff to the Services that include but not limited to the following: General a) Vision and mission of the Facility; b) Organisation chart and reporting structure of the Facility; c) Environment and facility safety policies and procedures including sustainability practices; d) Infection control policies and procedures;	1. Policy requiring all new staff to attend a structured orientation programme;						
	2. There is Services orientation programme with relevant topics not limited to topics covered from (a) to (q); and						
	3. Attendance list.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
e) Policies for performance management, patient safety (IPSG/MPSG) and risk management; f) Ethical practices and code of conduct including medicolegal awareness; g) Management of aggression, violence and harassment; and h) Patient and family rights. <u>Services</u> i) Goals, objectives and organisational structure of Services; j) Policies and procedures relevant to Services; k) Working instructions for patient care; and l) Service continuity plan for Services in response to internal and external disasters. <u>Job-specific</u> m) Explanation of particular duties and functions; n) Explanation of the methods of assigning clinical care and the standards of clinical practice; o) Handover communication; p) Training in basic/advanced life support techniques; and q) Technology and equipment use including artificial							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
intelligence, digital care and robotics.							
CRITERION 24.2.1.7							
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.	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; anf						
	4. Training module.						
CRITERION 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.	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; and						
	4. Certificate of attendance/degree/post basic training.						
CRITERION 24.2.1.9							
Staff receive evaluation of their performance at the completion of the probationary period and	1. Performance appraisal for staff is completed upon probationary period and as an annual exercise.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
annually thereafter, or as defined by the Facility.							
CRITERION 24.2.1.10							
In a teaching hospital and recognised training facility, the Service shall provide educational needs and teaching for undergraduates and postgraduates without compromising patient safety and comfort.	1. Sufficient skilled and trained staff to provide clinical supervision; and						
	2. Memorandum of Understanding.						
CRITERION 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.	1. Letter of appointment – Local Preceptor/ Clinical Instructor; and						
	2. Qualification and training records of local preceptor.						

STANDARD 24.2.2 (NEW)

The services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the staff, ensuring a safe and healthy work environment.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 24.2.2.1 (CORE) (NEW)							
The facility and biomedical services shall have provisions for the promotion of staff physical, mental, spiritual well-being and performance. a) A health-promoting environment, e.g., stress	1. The promotion of staff well-being may involve the following:						
		a. Evidence of a health promoting environment e.g., workplace wellness programme.					
		b. Evidence of proper supervision of staff; and					

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
management, burn out, staff engagement opportunities, workload monitoring, management of work life balance, healthy, lifestyle programmes e.g. Workplace Wellness Programs, Community-Based Health Initiatives; b) Staff shall be provided with appropriate supervision, support, and advice e.g., mentor mentee program; and c) There shall be clear procedures for the effective management of underperformance e.g., feedback on performance review or performance appraisal report.	c. Evidence of staff appraisal programme with feedback on underperformance.						
CRITERION 24.2.2.2 (CORE) (NEW)							
The Services shall establish a safe mechanism for staff to express grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety.	1. Staff suggestions and grievance reporting and processing mechanisms are available;						
	2. The resolution of workplace issues may involve the following:						
	a. Measures and evidence of facility and biomedical staff protection including whistleblowers against violence, bullying, and harassment e.g., awareness campaigns, anonymous						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	reporting channel, Whistleblower policy; and						
	b. Documented policies and procedures for violence activation and facility and staff protection.						
CRITERION 24.2.2.3 (NEW)							
A system shall be created to gather staff feedback about their workplace experience such as burnout which shall be analysed and used to make improvements that enhance the work environment, staff satisfaction, and organisation culture.	1. Staff feedback (e.g., minutes of sessions or staff satisfactions survey)						
	a. Evidence of action or improvement taken.						
CRITERION 24.2.2.4 (NEW)							
The services shall track sick leave and staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning.	1. Evidence that workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments. The results shall be used to create focused actions that improve staff well-being, solve problems, and help retain employees.						

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TOPIC 24.3
POLICIES AND PROCEDURES

STANDARD 24.3.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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, current standard practices and Patients and Family Rights. 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.	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; and						
	4. The policies and procedures are endorsed and dated.						
CRITERION 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	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; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
involved. Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.	3. Documented cross departmental policies.						
CRITERION 24.3.1.3							
Current policies and procedures are communicated to all staff	1. Training and briefing on the current policies and procedures/Minutes of meetings; and						
	2. Circulation list and acknowledgement						
CRITERION 24.3.1.4 (CORE)							
Policies and procedures are integrated in the care of patients incorporating but not limited to the following: a) Admission process; b) Pre procedure/investigation assessment; c) Intra procedure/ investigation protocols; d) Post procedure/investigation care; e) Transition of care process; f) Prevention & control of infection ; g) Environment of care for patients; and h) Discharge process . There is evidence of compliance with policies and procedures on various types of patients.	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; and					
		d. Practices in line with established policies and procedures.					

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 24.3.1.5							
Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are available and accessible to staff.	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.						

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TOPIC 24.4

FACILITIES AND EQUIPMENT

STANDARD 24.4.1
Adequate facilities and equipment are available to enable the services to meet their purposes.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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; and						
	4. Absence of overcrowding.						
CRITERION 24.4.1.2							
There is documented evidence that facilities and equipment in the Facility complies with relevant national/international standards and current statutory requirements.	1. Testing, commissioning and calibration records (certificates or stickers); and						
	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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Planned Preventive Maintenance records such as schedule, stickers, etc.						
	2. Planned Replacement Programme where applicable;						
	3. Complaint records; and						
	4. Asset inventory.						
CRITERION 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.	1. User training records;						
	2. Competency assessment record;						
	3. Letter of authorisation; and						
	4. List of staff trained and authorised to operate specialised equipment.						
CRITERION 24.4.1.5 (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care.						

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TOPIC 24.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 24.5.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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; and g) Innovation.	1. Planned performance improvement activities include (a) to (g); 2. Records on performance improvement activities; 3. Minutes of performance improvement meetings; 4. Performance improvement studies; and 5. Records on innovation if available.						
CRITERION 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.	1. Minutes of meetings; 2. Letter of assignment of responsibilities; and 3. Terms of Reference/Job description.						
CRITERION 24.5.1.3							
The Head of the Service shall ensure that the staff are trained and complete incident reports	1. System for incident reporting is in place, which include: a. Training of staff;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.	b. Policy on incident reporting;						
	c. Methodology of incident reporting; and						
	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; and						
	8. Feedback given to staff regarding incident reporting.						
CRITERION 24.5.1.4 (CORE)							
There is tracking and trending of at least two (2) specific performance indicators relevant to the service.	1. Specific performance indicators monitored;						
	2. Records on tracking and trending analysis; and						
	3. Remedial measures taken where appropriate.						
CRITERION 24.5.1.5 (NEW)							
The Services participates in the Facility's safety culture assessment. The results are utilized by Service leadership to inform and guide efforts to improve	1. Safety Culture Survey for staff.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
the culture of safety within the Service.							
CRITERION 24.5.1.6							
Feedback on results of safety and performance improvement activities are regularly communicated to the staff to promote transparency, shared learning, and active engagement in improvement initiatives.	1. Results on safety and performance improvement activities are accessible to staff through education sessions, meetings and digital communications.						
CRITERION 24.5.1.7							
Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.	1. Documentation on performance improvement activities and performance indicators; and						
	2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						

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SERVICE SUMMARY	
OVERALL RATING :	-
OVERALL RISK :	-

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SERVICE STANDARD 25: MEDICAL ASSISTANT SERVICES

PREAMBLE

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 health care. It includes the clinical and governance aspects of various disciplines in both medical and public health setting.

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.

TOPIC 25.1
ORGANISATION AND MANAGEMENT

STANDARD 25.1.1

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.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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 indicate safety, quality, and patient-centered care. These reflect the roles and aspirations	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 are measurable in line with the Facility statements are available, endorsed and dated;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
of the service and the needs of the community. These statements are monitored, reviewed, and revised as required accordingly and communicated to all staff.	3. Evidence of planned review of the above statements (at least once in 3 years or in the event of any major changes);						
	4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc.); and						
	5. Achievement of objectives are monitored, reviewed and revised accordingly.						
CRITERION 25.1.1.2 (CORE)							
The organisational structure of the services of Medical Assistants is clearly represented in one or more organization 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/Pembantu Perawatan Kesihatan (PPK) b) Is accessible to all staff and clients; and c) Is revised when there is a major change in any one of the following: i) Organisation;	1. Clearly delineated current organization 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/Pembantu Perawatan Kesihatan (PPK), and Healthcare Assistants (numbers only);						
	2. At each service level, a unit organization chart is available which reflects the working relationships between consultants, medical practitioners, Senior Medical Assistants, and Senior Healthcare Assistants/Pembantu Perawatan Kesihatan (PPK);						
	3. Organization chart of the service is endorsed, dated, and accessible; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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ii) Functions; iii) Reporting relationships; and iv) Staffing patterns	4. The organisation chart is reviewed when there is a major change in any of the items (c) (i) to (iv).						
CRITERION 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/ Pembantu Perawatan Kesihatan (PPK). 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 representation of the service;						
	3. Frequency of meetings as scheduled at least four (4) times a year; and						
	4. Discussion and resolutions are implemented.						
CRITERION 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.	1. Minutes of Facility-wide management meeting;						
	2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc.); and						
	3. Approved budget and resource.						
CRITERION 25.1.1.5							
The Chief Medical Assistant is involved in the assignment of staff.	1. Records on staff interview (if applicable);						
	2. Assignment letter of Head of Service (Chief Medical Assistant);						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	3. Job description of Head of Service (Chief Medical Assistant);						
	4. Records on staff assignment/deployment; and						
	5. Duty roster.						
CRITERION 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.	1. Records are available but not limited to the 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; and						
	f. Data on performance improvement activities, including performance indicators.						
CRITERION 25.1.1.7							
The Chief Medical Assistant heads the planning, development and evaluation of the services of Medical Assistants and Healthcare Assistants/ Pembantu Perawatan Kesihatan (PPK).	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; and						
	3. Minutes of meetings of steering committee/ team;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 25.1.1.8							
There is evidence that the services of Medical Assistants are involved in the development and implementation of new technologies.	1. Evidence of involvement of the Medical Assistants on development and implementation of new technologies; and						
	2. Minutes of departmental/ management meetings/ Attendance list.						
CRITERION 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: d) Time period; e) Liability; f) Review of terms of contract; g) Accountability for clinical practices; and h) Appointment of local preceptors from among the existing staffs.	1. Valid Memorandum of Understanding (MOU) or Agreement;						
	2. Ratio of Clinical Instructor (CI) and students commensurate with the number of students (1:15) in each discipline;						
	3. Student allocation roster for each discipline;						
	4. Standards and Guidelines for Medical Assistant Education Programme; and						
	5. Relevant documents of appointment for local preceptors.						
CRITERION 25.1.1.10 (NEW)							
The Head of Services shall ensure a basic Business	1. Documented and approved BCP for unanticipated situations;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment.						
	3. Clear actions and staff responsibilities during disruption;						
	4. Record of drills or tests, with follow-up actions, if conducted; and						
	5. Review of Risk Register.						

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TOPIC 25.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD 25.2.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Records of credentials of Chief Medical Assistant, all Medical Assistants and Healthcare Assistants/Pembantu Perawatan Kesihatan (PPK) 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; and						
	5. Records on deployment/ assignment of Medical Assistants according to experience and specialty training.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Valid appointment letters and Terms of Reference as member of committees stipulated by the Governing Body; and						
	2. Minutes of relevant committee meetings.						
CRITERION 25.2.1.3							
The Chief Medical Assistant shall designate suitably qualified Medical Assistants with delegated responsibilities for delivering of services for each unit.	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; and						
	4. On-call duty roster of Senior Medical Assistants.						
CRITERION 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; and iii) Experience of the various categories of Medical Assistants.	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; and						
	4. Verification of staffing needs in units as reflected by:						
	a. Current assigned duty roster;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
c) Contingency plan for staffing (mass casualty incidence, public health emergencies, turnover etc.).	b. Patient acuity level of care;						
	c. Skills mix; and						
	d. Written contingency plan (mass casualty incidence, public emergencies, turnover etc.)						
CRITERION 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; and vi) Statutory Regulations. e) Administrative, teaching, and clinical functions.	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.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 25.2.1.6 (CORE)							
The Chief Medical Assistant shall be responsible for the management, supervision, training and performance appraisal of Healthcare Assistants/Pembantu Perawatan Kesihatan (PPK).	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; and						
	8. Performance appraisal for Healthcare Assistants are completed upon probationary period and as an annual exercise.						
CRITERION 25.2.1.7 (CORE)							
There is a structured orientation programme for all newly appointed, contracted and outsourced staff to the Medical Assistant Services including medical practitioners and for those new to specific areas that include but not limited to the following: General	1. Policy requiring all new staff to attend a structured orientation programme;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
a) Vision and mission of the Facility; b) Organisation chart and reporting structure of the Facility; c) Environment and facility safety policies and procedures including sustainability practices; d) Infection control policies and procedures; e) Policies for performance management, patient safety (IPSG/MPSG) and risk management; f) Ethical practices and code of conduct including medicolegal awareness; g) Management of aggression, violence and harassment; and h) Patient and family rights. <u>Services</u> i) Goals, objectives and organisational structure of Medical Assistant Services; j) Policies and procedures relevant to Medical Assistant Services; k) Working instructions for patient care; and l) Service continuity plan for Medical Assistant Services in response to internal and external disasters. <u>Job-specific</u>	2. There is Medical Assistant Services orientation programme with relevant topics not limited to topics covered from (a) to (q).; and						
	3. Attendance list.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
m) Explanation of particular duties and functions; n) Explanation of the methods of assigning clinical care and the standards of clinical practice; o) Handover communication; p) Training in basic/advanced life support techniques; and q) Technology and equipment use including artificial intelligence, digital care and robotics.							
CRITERION 25.2.1.8							
The Chief Medical Assistant ensures all Medical Assistants and Healthcare Assistants/ Pembantu Perawatan Kesihatan (PPK) receive evaluation of their performance at the completion of the probationary period and annually.	1. Performance appraisal for all Medical Assistants and healthcare assistants is completed upon probationary period and as an annual exercise.						
CRITERION 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.	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; and						
	4. Training module.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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; and						
	4. Certificate of attendance/ degree/ post basic training.						
CRITERION 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.	1. Staff personal records include:						
	a. Curricular Vitae (CV);						
	b. Qualification and experience;						
	c. Evidence of current registration;						
	d. Training record;						
	e. Competency record and/or credentialing and privileging;						
	f. Attendance and leave record;						
	g. Confidentiality agreement; and						
	h. Deployment record outside hospital facility						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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/ privileged;						
	4. Signed Code of Conduct by Clinical Instructor; and						
	5. Minutes of joint meetings between the Chief Medical Assistant and the training college/institution.						
CRITERION 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	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; and						
	4. Formal letters of assignment or certificate of privileging with						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and e) The granting of privileges is approved by the Credentialing and Privileging Committee and certified by the Person in Charge (PIC)/ Governing Body.	stipulated timeline are issued and reviewed accordingly.						

STANDARD 25.2.2 (NEW)

The Medical Assistant Services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the Medical Assistant Services staff, ensuring a safe and healthy work environment.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 25.2.2.1 (CORE)							
The Medical Assistant Services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being. a) A health-promoting environment, e.g., stress management, burn out, staff engagement opportunities, workload monitoring, management of work life balance, healthy, lifestyle programmes e.g. Workplace Wellness Programs,	1. The promotion of staff well-being may involve the following:						
	a. Evidence of a health promoting environment e.g., workplace wellness programme;						
	b. Evidence of proper supervision of staff; and						
	c. Evidence of staff appraisal programme with feedback on underperformance.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Community-Based Health Initiatives; b) Staff shall be provided with appropriate supervision, support, and advice e.g., mentor mentee program; and c) There shall be clear procedures for the effective management of underperformance e.g., feedback on performance review or performance appraisal report.							
CRITERION 25.2.2.2 (CORE)							
The Medical Assistant Services shall establish a safe mechanism for Medical Assistant Services staff to express grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety.	1. Medical Assistant Services staff suggestions and grievance reporting and processing mechanisms are available;						
	2. The resolution of workplace issues may involve the following:						
	a. Measures and evidence of Medical Assistant Services staff protection including whistleblowers against violence, bullying, and harassment e.g., awareness campaigns, anonymous reporting channel, Whistleblower policy; and						
	b. Documented policies and procedures for violence activation and Medical Assistant Services staff protection.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 25.2.2.3 (NEW)							
A system shall be created to gather Medical Assistant Services staff feedback about their workplace experience such as burnout which shall be analysed and used to make improvements that enhance the work environment, Medical Assistant Services staff satisfaction, and organisation culture.	1. Medical Assistant Services staff feedback (e.g., minutes of sessions or Medical Assistant Services staff satisfactions survey):						
	a. Evidence of action or improvement taken.						
CRITERION 25.2.2.4 (NEW)							
The Medical Assistant Services shall track sick leave and Medical Assistant Services staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning	1. Evidence that workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments. The results shall be used to create focused actions that improve staff well-being, solve problems, and help retain employees						

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TOPIC 25.3
POLICIES AND PROCEDURES

STANDARD 25.3.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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, current standard practices and Patients and Family Rights 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;	1. Documented Policies and Procedures, Protocols, Manuals and Guidelines are available to guide Medical Assistants for:						
		a. General care of all patients; and					
		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; and						
	4. The policies and procedures are endorsed and dated.						

DISTRIBUTION

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and xvi) Public health emergency. 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.							
CRITERION 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.	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; and						
	3. Cross departmental policies and procedures, e.g. Inter-Hospital Transfer in which a policy is developed, e.g. between						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	Ambulance and Transport Services (CMA), Porterage Services.						
CRITERION 25.3.1.3							
Current policies and procedures are communicated to all staff of the Medical Assistant Services.	1. Training and briefing on the current policies and procedures/ Minutes of meetings; and						
	2. Circulation list and acknowledgement.						
CRITERION 25.3.1.4 (CORE)							
There is evidence of compliance with policies and procedures.	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; and						
	d. Practices in line with established policies and procedures.						
CRITERION 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.	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site/workstation for staff reference.						
CRITERION 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.	1. Policies and procedures for the Medical Assistant Services are endorsed by the Chief Medical Assistant.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 25.3.1.7							
The Medical Assistants participate in planning, decision making and formulation of polices of the Facility.	1. List of committees where the Chief Medical Assistant is involved; and						
	2. Minutes of Management meetings.						
CRITERION 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; and f) Patient education which shall be documented, e.g. Outpatient Clinic, Orthopedics, Dermatology and Eye Clinics; Hemodialysis and Asthma patients.	1. Evidence of implementation and documentation of practices (a) to (f); signed/ stamped and dated, e.g. patient's medical records; and						
	2. Compliance to relevant National Patient Safety Goals.						

TOPIC 25.4
FACILITIES AND EQUIPMENT

STANDARD 25.4.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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; and						
	5. Absence of overcrowding.						
CRITERION 25.4.1.2							
Medical Assistants are provided with sufficient supplies and equipment at all times, including appropriate personal protective equipment.	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; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	5. Equipment has valid Planned Preventive Maintenance (PPM).						
CRITERION 25.4.1.3							
Facilities which provide training shall have specific areas for training and rooms for tutorial.	1. Availability of training/ tutorial areas/ rooms.						
CRITERION 25.4.1.4 (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care.						

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TOPIC 25.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 25.5.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 25.5.1.1							
There are periodical 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; g) Innovation.	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 and						
	5. Recordands of innovation if available.						
CRITERION 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.	1. Minutes of Meetings;						
	2. Letter of assignment of responsibilities; and						
	3. Job description.						
CRITERION 25.5.1.3 (CORE)							
The Chief Medical Assistant shall ensure that the staff are trained and complete incident reports (where applicable) which are	1. System for incident reporting is in place, which include:						
	a. Training of staff;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.	b. Policy on incident reporting;						
	c. Methodology of incident reporting; and						
	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; and						
	8. Feedback given to staff regarding incident reporting.						
CRITERION 25.5.1.4 (CORE)							
The Medical Assistant Services shall conduct tracking and trending of the following specific performance indicators: a) Number of fire drill that has been carried out by the hospital in the corresponding year; b) Fire Drill at hospital level: Once a year; c) Tabletop Exercise at hospital level: Twice a year (Once in 6 months); d) Dispatch and Ambulance Preparedness of Primary Response. (Target: ≥90%)	1. Specific performance indicators monitored;						
	2. Reports on Fire Drill and Tabletop Exercise; and						
	3. Remedial measures taken where appropriate.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
i) Percentage of Medical Assistants in Emergency Services trained in Advanced Life Saving Course. (Target: Non-specialist hospital: ≥30%, Specialist hospital: ≥50%); ii) Percentage of Medical Assistants with post basic qualification and advance training in relevant disciplines. (Target: ≥40%); iii) 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); and iv) AMO with Post Basic assigned to relevant specialization unit/department. (Target: ≥80%).							
CRITERION 25.5.1.5 (NEW)							
The Services participates in the Facility's safety culture assessment. The results are utilized by Service leadership to inform and guide efforts to improve the culture of safety within the Service.	1. Safety Culture Survey for staff						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 25.5.1.6							
Feedback on the results of safety and performance improvement activities is regularly communicated to the staff to promote transparency, shared learning, and active engagement in improvement initiatives.	1. Results of safety and performance improvement activities are accessible to staff through education sessions, meetings and digital communications.						
CRITERION 25.5.1.7							
Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.	1. Documentations on performance improvement activities and performance indicators; and						
	2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						

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TOPIC 25.6
SPECIAL REQUIREMENTS
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:

a) **Role in Environmental and Safety Services;**
b) **Role as Fire Safety Officer;**
c) **Role in External/Internal Disaster Management;**
d) **Role in Clinical Supervision; and**
e) **Roles in Specific Clinical Services.**

STANDARD 25.6.1
ROLE IN ENVIRONMENTAL AND SAFETY SERVICES
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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) i) External Disaster; and ii) ii) Internal Disaster. d) Hazardous Material and Recyclable Waste Management. (*) where applicable	1. Operational policies of the Environmental and Safety Services address activities (a) to (f); and						
	2. Terms of reference on the role and responsibilities of assigned Medical Assistant to address activities (a) to (f).						
CRITERION 25.6.1.2							
There is clear evidence of coordination and cooperation amongst the various Medical	1. Minutes of meetings of the coordination meetings.						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.							
CRITERION 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.	1. Attendance to relevant training; and						
	2. Staff training records						

STANDARD 25.6.2
ROLE AS FIRE SAFETY OFFICER
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)]

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Letter of assignment of Chief Medical Assistant as member of Fire Safety Committee and Fire Safety Officer with Terms of Reference; and						
	2. Appropriate training and experience as Fire Safety Officer.						
CRITERION 25.6.2.2 (CORE)							
The Chief Medical Assistant who is the Fire Safety Officer shall	1. Fire Prevention and Surveillance Plans that have been endorsed and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
prepare, implement and review the Fire Prevention and Surveillance Plan.	dated by the Person in Charge (PIC).						
CRITERION 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.	1. Fire Safety training schedules; and						
	2. Certification/ list of attendance.						
CRITERION 25.6.2.4							
Fire drills are conducted at least once a year based on the fire prevention and control plan.	1. Reports on fire drills;						
	2. Identifying shortfalls;						
	3. Minutes of meetings of pre and post drills; and						
	4. Remedial actions planned and implemented.						
CRITERION 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.	1. List of identified personnel for the purpose; and						
	2. Evidence of appropriate training to the selected personnel.						
CRITERION 25.6.2.6 (CORE)							
The Fire Safety Officer shall conduct Fire Audit in the wards/ units regularly.	1. Audit Schedules;						
	2. List of Auditors; and						
	3. Reports of audits.						

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STANDARD 25.6.3
ROLE IN EXTERNAL/INTERNAL DISASTER MANAGEMENT
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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).	1. Valid appointment letters and Terms of Reference as member of committees stipulated by the Governing Body; and						
	2. Minutes of relevant committee meetings.						
CRITERION 25.6.3.2 (CORE)							
The Chief Medical Assistant shall coordinate in the preparation, implementation and review of the External/ Internal Disaster Management Policy.	1. The Internal/External Disaster Management Plans that has been endorsed and dated by the Person In Charge (PIC).						
CRITERION 25.6.3.3							
The Chief Medical Assistant shall organise and implement training for internal/ external disaster management teams.	1. Internal/ External Disaster Management Training schedules; and						
	2. Certification/ list of attendance.						
CRITERION 25.6.3.4							
Internal/ External Disaster drills are conducted at least once a year.	1. Reports on disaster drills;						
	2. Identifying shortfalls;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	3. Minutes of meetings of pre and post drills; and						
	4. Remedial actions planned and implemented.						
CRITERION 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.	1. List of identified personnel for the purpose; and						
	2. Evidence of appropriate training to the selected personnel.						

STANDARD 25.6.4
ROLE IN CLINICAL SUPERVISION
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).

Reference:
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 25.6.4.1 (CORE)							
The Chief Medical Assistant shall carry out clinical supervision rounds periodically in an	1. An approved supervisory schedule/ roster for a year;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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.	2. Records/ reports on supervision in clinical areas; and						
	3. Evidence of review on records/ reports on supervision in clinical areas by management.						
CRITERION 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.	1. Standard operating procedures and guidelines relevant to the clinical practice;						
	2. Evidence of adherence to the standard operating procedures; and						
	3. Records of non-adherence and the remedial actions.						

STANDARD 25.6.5
ROLE IN SPECIFIC CLINICAL SERVICES
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:

1. ***Emergency & Trauma Services and Pre Hospital Care;***
2. ***Nephrology Services;***
3. ***Psychiatry & Mental Health Services;***
4. ***Community Psychiatry Services;***
5. ***Intensive Care Services and Hemodynamic Services;***
6. ***Orthopedic Services;***
7. ***Ophthalmology Services;***
8. ***Otorhinolaryngology Services;***
9. ***Peri-Anaesthesia and Anesthetic Services (Sabah & Sarawak);***
10. ***Forensic/Mortuary Services;***
11. ***Cardiology Services;***
12. ***Neurophysiology Services;***

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13. ***Urology Services;***
14. ***Cardiothoracic Surgery Services;***
15. ***Cardiothoracic Anesthesiology & Perfusion;***
16. ***Hand & Microsurgery Services;***
17. ***Hepatobiliary Surgery Services;***
18. ***Plastic & Reconstructive Surgery Services;***
19. ***Dermatology Services;***
20. ***Rehabilitation Medicine Services;***
21. ***Oncology Services;***
22. ***Nuclear Medicine Services;***
23. ***Respiratory Medicine Services;***
24. ***Endoscopy Services;***
25. ***Neurosurgical Services;***
26. ***Obstetric & Gynecology Services;***
27. ***Vascular Surgery Services;***
28. ***Paediatric Services;***
29. ***General Medicine Services; and***
30. ***General Surgery Services***

In addition to the above, the Medical Assistant Services also conduct teaching and training, research and audit activities where applicable.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 25.6.5.1 (CORE)							
The Chief Medical Assistant shall ensure that appropriately qualified and competent Medical Assistants are deployed as per general or/ and special requirements of the specialized services. General Requirements	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;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
a) Undergo tagging for three (3) months after assigned to the specific clinical services; and b) Privileged in specific procedures related to the specific clinical services within six (6) months after tagging period. **Specific Requirements by Certain Specific Clinical Services** c) Emergency & Trauma Services and Pre Hospital Care: i) All Medical Assistants shall be trained in Basic Life Support (BLS) within two (2) months after being placed in the Emergency Services; and ii) All Medical Assistants in the Emergency Services shall continuously participate in Advanced Life Saving Course (e.g. Malaysian Trauma Life Support MTLS) Advanced Life Support (ALS)/ Advanced Cardiac Life Support (ACLS)/ Pediatric Advanced Life Support (PALS)] or any advanced program done by related training provider within two (2) years after being placed in the Emergency Services. d) Nephrology Services:	4. Reports of Chief Medical Assistant's supervision of Medical Assistants deployed to specific clinical disciplines; and						
	5. Documentation on remedial actions found during the supervision and audit on clinical practice.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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. e) Psychiatry & Mental Health Services: 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 Electroconvulsive therapy (ECT) shall possess a post basic certificate in Peri Anesthesia/ Anesthesia. f) Anaesthesia and Intensive Care Services: 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 work more than five (5) years in the Anesthesia and Intensive							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Care Services should attend post basic training in Peri-Anesthesia or Advance Diploma Intensive Care (Technology) or Anesthesia (Sabah & Sarawak); and iii) All Medical Assistants (Intensive Care Technologists, Anesthetic Assistant and Technologists) who work more than (5) years in the Anesthesia and Intensive Care Services shall be credentialed at the Ministry of Health (MOH) level by National Credentialing Committee. g) Ophthalmology Services: i) 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; and ii) All Medical Assistants shall attend post basic course in Ophthalmic Nursing within five (5) years of after being posted in the Ophthalmology Services							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
h) Neurophysiology Services: i) All Medical Assistants assigned to work in the specialist department should undergo a post basic course in Neurophysiology Clinical within.five (5) years after being posted . i) Cardiothoracic Surgery Services: i) All Medical Assistants assigned to work in Cardiothoracic Unit shall be trained in Basic Life Support (BLS) within three (3) years after being placed in the Cardiothoracic Surgery Department/Unit. j) Endoscopy Services: 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 least three (3) months of tagging and attend a post basic course in Endoscopy Clinical within five (5) years; and							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
iii) All Medical Assistants in the Endoscopy Unit shall continuously participate in any program organized by related training provider. k) Neurosurgical Services: i) All Medical Assistants assigned to work in the specialist department should undergo a relevant post basic course (Neuroscience, Perioperative) within five (5) years.							
CRITERION 25.6.5.2 (CORE)							
Forensic Services/ Mortuary Services 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.	1. Records on attachment training in facility with specialist services; and 2. Approval by the relevant authority to confirm that the Medical Assistants allowed to work independently in the Forensic Services of non-specialist facility.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Records of probationary period of all Medical Assistants; and						
	2. Approval by the relevant authority in allowing the Medical Assistants to work independently.						

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SERVICE SUMMARY	
OVERALL RATING :	-
OVERALL RISK :	-

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SERVICE STANDARD 26: CLINICAL RESEARCH CENTRE

PREAMBLE

Clinical research is a branch of healthcare science that investigate/research/explore 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. Clinical research is often conducted at academic medical centres and affiliated research study sites, i.e. hospitals. The Clinical Research Centre (CRC) is organized 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. 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.

TOPIC 26.1
ORGANISATION AND MANAGEMENT

STANDARD 26.1.1

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.

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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 indicate 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,	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 are measurable in line with the Facility statements are available, endorsed and dated;						
	3. Evidence of planned reviews of the above statements (at least once in						

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reviewed, and revised as required accordingly and communicated to all staff.	3 years or in the event of any major changes);						
	4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc); and						
	5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.						
CRITERION 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 the Clinical Research Centre; b) Provides a clear representation of the structure, functions, and reporting relationships between the Clinical Research Centre and Hospital organisation; c) Is accessible to all staff and clients; d) Includes off-site services if applicable; and e) Is revised when there is a major change in any of the following: i) Organisation; ii) Functions;	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 and between Clinical Research Centre and Institute of Clinical Research;						
	3. Organisation chart of the service is endorsed, dated and accessible; and						
	4. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
iii) Reporting relationships; and iv) Staffing patterns.							
CRITERION 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.	1. Minutes are accessible, disseminated and acknowledged by the staff;						
	2. Attendance list of members with adequate representation of the service;						
	3. Frequency of meetings as scheduled; and						
	4. Discussion and resolutions are implemented.						
CRITERION 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.	1. Minutes of Facility-wide management meeting;						
	2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service; and						
	3. Approved budget and resources.						
CRITERION 26.1.1.5							
The Head of FCRC is involved in the appointment and/OR assignment of staff.	1. Records on staff interview (if applicable);						
	2. Appointment/assignment letter of Head of Service;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	3. Job description of Head of Service;						
	4. Records on staff deployment; and						
	5. Duty roster.						
CRITERION 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.	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; and						
	f. Data on performance improvement activities, including performance indicators.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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; 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	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 Organisation (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.; and						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and j) Visits to the facilities of the external service provider by the staff of FCRC to ensure requirements of standards are met.	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).						
CRITERION 26.1.1.8 (NEW)							
The Head of Services shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	1. Documented and approved BCP for emergency services. unanticipated situations;						
	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood; b. Impact; c. Assigned ownership, and d. Risk treatment.						
	3. Clear actions and staff responsibilities during disruption;						
	4. Record of drills or tests, with follow-up actions, if conducted; and						
	5. Review of Risk Register.						

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TOPIC 26.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD 26.2.1
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.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Head and all trained staff of FCRC shall have a valid professional Annual Practising Certificate (APC), privileging, and Good Clinical Practice (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 (such as CV & TOR); and						
	4. Training and competency records.						
CRITERION 26.2.1.2							
The authority, responsibilities, and accountabilities of the Head of FCRC are clearly delineated and documented.	1. Appointment/assignment letter and Term of Reference for Head of FCRC from relevant authority; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	2. Description of duties and responsibilities.						
CRITERION 26.2.1.3							
Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the need of the FCRC.	1. Number of staff and qualification should commensurate with workload;						
	2. Staffing pattern;						
	3. Duty roster; and						
	4. Census and statistics.						
CRITERION 26.2.1.4							
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;	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; and						
	4. The job description is acknowledged by the staff and signed by the Head of Service and dated.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
iii) General and specific accountabilities; iv) Qualifications required and privileges granted; v) Staffing patterns; and vi) Statutory Regulations. e) Administrative and clinical functions.							
CRITERION 26.2.1.5							
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	1. Staff personal records include:						
	a. Curricular Vitae (CV);						
	b. Qualification and experience;						
	c. Evidence of current registration;						
	d. Training record;						
	e. Competency record and/or credentialing and privileging;						
	f. Attendance and leave record;						
	g. Confidentiality agreement; and						
	h. Deployment record outside hospital facility.						
CRITERION 26.2.1.6							
There is a structured orientation programme for all newly appointed, contracted and	1. Policy requiring all new staff to attend a structured orientation programme;						

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outsourced staff to the FCRC including medical practitioners and for those new to specific areas that include but not limited to the following: <u>General</u> a) Vision and mission of the Facility; b) Organisation chart and reporting structure of the Facility; c) Environment and facility safety policies and procedures including sustainability practices; d) Infection control policies and procedures; e) Policies for performance management, patient safety (IPSG/MPSG) and risk management; f) Ethical practices and code of conduct including medicolegal awareness; g) Management of aggression, violence and harassment; and h) Patient and family rights. <u>Services</u> i) goals, objectives and organisational structure of FCRC; j) policies and procedures relevant to FCRC; k) working instructions for patient care; and	2. There is FCRC Services orientation programme with relevant topics not limited to topics covered from (a) to (q); and						
	3. Attendance list.						

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l) service continuity plan for FCRC in response to internal and external disasters. <u>Job-specific</u> m) Explanation of particular duties and functions; n) Explanation of the methods of assigning clinical care and the standards of clinical practice; o) Handover communication; p) Training in basic/advanced life support techniques; and q) Technology and equipment use including artificial intelligence, digital care and robotics.							
CRITERION 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.	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; and						
	4. Training module.						

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CRITERION 26.2.1.8							
There are continuing education activities for staff including medical practitioners to pursue professional interests and to prepare for current and future changes in practice.	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; and						
	4. Certificate of attendance/degree/post basic training.						
CRITERION 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.	1. Performance appraisal for staff is completed upon probationary period and as an annual exercise.						
CRITERION 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.	1. Record on mentoring and relevant research training for undergraduates and postgraduates as determined by the Facility; and						
	2. Memorandum of Understanding.						
CRITERION 26.2.1.11							
In Facilities which have teaching and research responsibilities, the	1. Documentation on participation in a teaching/research						

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staff of the FCRC give their cooperation or participate in the teaching and research programmes as determined by the Facility.	training/mentoring as determined by the Facility.						

STANDARD 26.2.2 (NEW)
The FCRC shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the FCRC staff, ensuring a safe and healthy work environment.

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CRITERION 26.2.2.1 (CORE)							
The shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being. a) A health-promoting environment, e.g., stress management, burnout, staff engagement opportunities, workload monitoring, management of work life balance, healthy, lifestyle programmes e.g. Workplace Wellness Programs, Community-Based Health Initiatives; b) Staff shall be provided with appropriate supervision, support, and advice e.g., mentor mentee program; and c) There shall be clear procedures for the effective	1. The promotion of staff well-being may involve the following:						
	a. Evidence of a health promoting environment e.g., workplace wellness programme;						
	b. Evidence of proper supervision of staff; and						
	c. Evidence of staff appraisal programme with feedback on underperformance.						

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
management of underperformance e.g., feedback on performance review or performance appraisal report.							
CRITERION 26.2.2.2 (CORE)							
The FCRC shall establish a safe mechanism for FCRC staff to express grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety.	1. FCRC staff suggestions and grievance reporting and processing mechanisms are available; and						
	2. The resolution of workplace issues may involve the following:						
	a. Measures and evidence of FCRC staff protection including whistleblowers against violence, bullying, and harassment e.g., awareness campaigns, anonymous reporting channel, Whistleblower policy; and						
	b. Documented policies and procedures for violence activation and FCRC staff protection.						
CRITERION 26.2.2.3 (NEW)							
A system shall be created to gather FCRC staff feedback about their workplace experience such as burnout which shall be analysed and used to make improvements that enhance the work environment, FCRC staff	1. FCRC staff feedback (e.g., minutes of sessions or FCRC staff satisfactions survey):						
	a. Evidence of action or improvement taken.						

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satisfaction, and organisation culture.							
CRITERION 26.2.2.4 (NEW)							
The FCRC shall track sick leave and FCRC staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning	1. Workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments; and						
	2. The results shall be used to create focused actions that improve staff well-being, solve problems, and help retain employees.						

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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.

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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, current standard practices and Patients and Family Rights. 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.	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, Sale of Drugs Act 1952 + Control of Drugs and Cosmetics Regulations 1984, 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;						

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	3. Evidence of periodic review of policies and procedures; and						
	4. The policies and procedures are endorsed and dated.						
CRITERION 26.3.1.2 (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 practiced in developing relevant policies and procedures where applicable.	1. Minutes of committee meetings on development and revision on policies and procedures;						
	2. Minutes of meetings with evidence of cross-reference with other departments, e.g., Hospital Research Committee; and						
	3. Documented cross departmental policies						
CRITERION 26.3.1.3							
Current policies and procedures are communicated to all staff.	1. Training and briefing on the current policies and procedures/Minutes of meetings; and						
	2. Circulation list and acknowledgement.						
CRITERION 26.3.1.4 (CORE)							
There is evidence of compliance with policies and procedures.	1. Compliance with policies and procedures through:						
	a. Interview of staff on practices (where applicable);						
	b. Verify with observation on practices;						

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	c. Results of audit on practices; and						
	d. Practices in line with established policies and procedures.						
CRITERION 26.3.1.5							
Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws, and statutory requirements are accessible on-site for staff reference.						
CRITERION 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.	1. Adequate standard process sequence and interaction of the processes provided by the FCRC.						
CRITERION 26.3.1.7							
There are written sequence and interaction of the processes provided by the FCRC	1. Adequate documentation on sequence and interaction of the processes provided by the FCRC.						
CRITERION 26.3.1.8							
Resources and information needed to support the monitoring and operation of these processes shall be made available.	1. Adequate resources and information to support the monitoring and operation of these processes shall be made available.						

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TOPIC 26.4
FACILITIES AND EQUIPMENT

STANDARD 26.4.1
Adequate facilities and equipment are available to enable the FCRC to meet its goals and objectives.

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CRITERION 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.	1. Adequate and proper utilisation of space;						
	2. Appropriate type of equipment to match the complexity of services; and						
	3. Easy access and clear exit routes.						
CRITERION 26.4.1.2							
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); and						
	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.						
CRITERION 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	1. Planned Preventive Maintenance records such as schedule, stickers, etc.;						
	2. Planned Replacement Programme where applicable;						

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the facilities and equipment are in good working order.	3. Complaint records; and						
	4. Asset inventory						
CRITERION 26.4.1.4 (CORE)							
Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.	1. User training records;						
	2. Competency assessment record;						
	3. Letter of authorisation;						
	4. List of staff trained and authorised to operate specialised equipment; and						
	5. Provision of PPE (where applicable).						
CRITERION 26.4.1.5 (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care (Eg: procurement of energy-efficient equipment, ppm and calibration to prolong equipment lifespan, digital temperature monitoring to reduce pharmaceutical wastage, proper waste segregation practices, and optimisation of shared facilities and equipment to minimise resource duplication.)						

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TOPIC 26.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 26.5.1
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 improvement activities will be consistent with the quality objectives of the FCRC towards contributing to the quality objectives of the Facility.

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CRITERION 26.5.1.1							
The FCRC is required to conduct risk assessment that could be relevant to patients/service users and/or staff based on: d) 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); and iv) Risk of research misconduct involving individual or team. The FCRC shall have an appropriate mitigation plan for the risks determined by the Facility.	1. Documented policies and procedures for risk assessment plan – Risk Registry;						
	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; and						
	e. Feedback given						
CRITERION 26.5.1.2							
Procedures in research and clinical trials, these could include (if applicable to FCRC):	1. Documented policies and procedures for risk assessment plan;						

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
a) Genetic and genomic testing; b) Medical and healthcare device e.g., robotics device, 3D, applications, and etc; c) Equipment and procedure risks, e.g., fire/injury, sharp injuries, and etc; d) Research recruitment strategy; e) Unauthorised personnel to perform research-related activities; and f) Unreliable research data.	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; and						
	g. Feedback given.						
CRITERION 26.5.1.3							
Risk of chemical hazard, biological hazard, physical hazard of FCRC with laboratory facilities, these could relate to (if applicable)	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;						

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	d) Acknowledgement by Head of Service and PIC/Hospital Director; and						
	e) Feedback given.						
CRITERION 26.5.1.4							
Risks of incident involving Investigational product (IP) or medical devices (MD) (if applicable): a) Discoloration; b) Broken/malfunction; and c) Others	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; and						
	e) Feedback given.						

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					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 26.5.1.5							
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.	1. System for incident reporting is in place, which include:						
	a. Training of staffs;						
	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; and						
	8. Feedback given to staff regarding incident reporting.						

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CRITERION 26.5.1.6							
The FCRC shall oblige to any quality audit processes from either the Facility or relevant regulatory or certifying bodies.	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.						
CRITERION 26.5.1.7							
There shall be participation from among FCRC staff in the monitoring and audit processes of the Facility.	1. Evidence of participation among FCRC staff in the monitoring and audit process of the Facility.						
CRITERION 26.5.1.8							
The Head of FCRC ensures necessary actions shall be implemented to achieve planned results in line with the FCRC quality objectives.	1. Relevant records on implementation of actions taken evidenced on- site.						
CRITERION 26.5.1.9							
Whenever relevant, the quality procedures shall be reviewed by the FCRC management in the interest of improvements to the Facility and FCRC quality systems.	1. Adequate records on reviews and amendments by the FCRC management in the interest of improvements to the facility's and FCRC quality systems.						
CRITERION 26.5.1.10 (CORE)							
There is tracking and trending of specific performance indicators not limited to but at least two (2) of the following:	1. Written document for performance improvement activities;						
	2. Assigned individual/committee for performance improvement activities;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
a) Number of training conducted per year (Target : minimum of 2 per year); b) Number of publications per year (Target : minimum 2 per year); and c) Number of consultations per year (Target: minimum 2 consultations per consulting officer per year)	3. Records on safety and performance improvement activities;						
	4. Records on training conducted or part of organising committee per year, e.g. Good Clinical Practise (GCP), Introduction to Clinical Research (ICR) and etc.						
	5. Records on Hospital/Facility Publication per year; and						
	6. Records on consultations conducted						
CRITERION 26.5.1.11 (NEW)							
The Services participates in the Facility's safety culture assessment. The results are utilized by Service leadership to inform and guide efforts to improve the culture of safety within the Service.	1. Safety Culture Survey for staff						
CRITERION 26.5.1.11							
Feedback on the results of safety and performance improvement activities are regularly communicated to the staff to promote transparency, shared learning, and active engagement in improvement initiatives.	1. Results on safety and performance improvement activities are accessible to staff through education sessions, meetings and digital communications.						
CRITERION 26.5.1.12							
Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical	1. Documentation on performance improvement activities and performance indicators; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
practitioners, staff and patients is preserved.	2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						
CRITERION 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.	1. Documentation on Emergency / Contingency Plan; and						
	2. Documented of FCRC staff responsibilities during emergency/disaster.						

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TOPIC 26.6
SPECIAL REQUIREMENTS

STANDARD 26.6.1
Research (Industrial Sponsored Research, ISR) or Investigator Initiated Research (IIR).

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 26.6.1.1 (CORE)							
The research (Industrial Sponsored Research, ISR) or Investigator Initiated Research (IIR) shall obtain approval from relevant authority.	1. Adequate documentation in hard copy/ soft copy on approval from relevant authority.						

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SERVICE SUMMARY	
OVERALL RATING :	-
OVERALL RISK :	-

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SERVICE STANDARD 27 : DECEASED ORGAN AND TISSUE DONATION & PROMOTION

PREAMBLE

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. Promotional activity in this service is responsible for the education of both healthcare professionals and the public in organ and tissue donation. This service is part of a multidisciplinary team for the transplantation activity in this country.

TOPIC 27.1
ORGANISATION AND MANAGEMENT

STANDARD 27.1.1

The deceased organ and tissue donation services shall be organised and administered by trained and qualified Transplant Procurement Manager & Transplant Coordinator 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

A basic Business Continuity Management (BCM) programme shall also be developed and maintained to support the uninterrupted delivery of services. All activities shall align with applicable Acts, Regulations, By Laws and the Facility's strategic priorities.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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 are measurable in line with the Facility statements available, endorsed and dated;						
	3. Evidence of planned reviews of the above statements (at least once in 3 years or in the event of any major changes);						
	4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc); and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	5. Achievement of goals and objectives are monitored, reviewed and revised accordingly.						
CRITERION 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; and d) Is revised when there is a major change in any of the following: i) Organisation; ii) Functions; iii) Reporting relationships; and iv) Staffing patterns	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; and						
	3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).						
CRITERION 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; decisions and resolutions made during meetings shall be accessible,	1. Minutes are accessible, disseminated and acknowledged by the staff;						
	2. Attendance list of members with adequate representation of the service;						
	3. Frequency of meetings as scheduled; and						
	4. Discussion and resolutions are implemented.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
communicated to all staff of the service, and implemented.							
CRITERION 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.	1. Minutes of Facility-wide management meeting;						
	2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service; and						
	3. Approved budget and resources.						
CRITERION 27.1.1.5							
The Head of Department is involved in the appointment and/OR assignment of staff	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; and						
	5. Duty roster.						
CRITERION 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.	1. Records are available but not limited to the following:						
	a. Workload/census;						
	b. Annual report;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	c. Accident/incident reports;						
	d. Staffing number and staff profile;						
	e. Staff training records; and						
	f. Data on performance improvement activities, including performance indicators.						
CRITERION 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; and d) Procurement activity	1. Records are signed, dated and designation stated						
CRITERION 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;	1. Written agreement which include (a) to (i) between the external service provider and the Facility is endorsed, signed and dated.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
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; and i) Comply with the appropriate MSQH Standards of Accreditation for that part of the service which functions within the Facility.							
CRITERION 27.1.1.9 (NEW)							
The Head of Services shall ensure a basic Business Continuity Plan (BCP) is in place to maintain critical emergency functions during service disruptions. The plan shall be based on service priorities and	1. Documented and approved BCP for unanticipated situations;						
	2. List of key emergency functions and identified risks, documented in a department-level Risk Register. This Risk Register includes: a. Likelihood;						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
potential risks, and include key actions, responsible staff, and alternative arrangements to continue care.	b. Impact; c. Assigned ownership, and d. Risk treatment.						
	3. Clear actions and staff responsibilities during disruption;						
	4. Record of drills or tests, with follow-up actions, if conducted; and						
	5. Review of Risk Register.						

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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	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 27.2.1.1 (CORE)							
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.	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; and						
	4. Training and competency records.						
CRITERION 27.2.1.2							
The authority, responsibilities and accountabilities of the Head of Services are clearly delineated and documented.	1. Appointment/assignment letter for Head of Service; and						
	2. Description of duties and responsibilities.						
CRITERION 27.2.1.3							
Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the needs of the services.	1. Number of staff and qualification should commensurate with workload;						
	2. Staffing pattern;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
	3. Duty roster; and						
	4. Census and statistics.						
CRITERION 27.2.1.4							
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; and 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; and						
	4. The job description is acknowledged by the staff and signed by the Head of Service and dated.						
CRITERION 27.2.1.5							
Personnel records on training, staff development, leave and others are maintained for every staff.	1. Staff personal records include:						
	a. Curricular Vitae (CV);						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Note: Staff personal record may be kept in Human Resource Department as per Facility policy	b. Qualification and experience;						
	c. Evidence of current registration;						
	d. Training record;						
	e. Competency record and/or credentialing and privileging;						
	f. Leave record;						
	g. Confidentiality agreement; and						
	h. Deployment record outside hospital facility.						
CRITERION 27.2.1.6							
There is a structured orientation programme for all newly appointed, contracted and outsourced staff to the deceased organ and tissue donation services including medical practitioners and for those new to specific areas that include but not limited to the following: General a) Vision and mission of the Facility; b) Organisation chart and reporting structure of the Facility; c) Environment and facility safety policies and procedures including sustainability practices	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 (q); and						
	3. Attendance list.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
d) Infection control policies and procedures; e) Policies for performance management, patient safety (IPSG/MPSG) and risk management; f) Ethical practices and code of conduct including medicolegal awareness; g) Management of aggression, violence and harassment; and h) Patient and family rights. <u>Services</u> i) Goals, objectives and organisational structure of deceased organ and tissue donation services; j) Policies and procedures relevant to deceased organ and tissue donation services; k) Working instructions for patient care; and l) Service continuity plan for deceased organ and tissue donation services in response to internal and external disasters <u>Job-specific</u> m) Explanation of particular duties and functions; n) Explanation of the methods of assigning clinical care and the standards of clinical practice; o) Handover communication;							

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
p) Training in basic/advanced life support techniques; and q) Technology and equipment use including artificial intelligence, digital care and robotics.							
CRITERION 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.	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; and						
	4. Training module.						
CRITERION 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.	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; and						
	4. Certificate of attendance/degree/post basic training.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	1. Performance appraisal for staff is completed upon probationary period and as an annual exercise.						
CRITERION 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.	1. Sufficient skilled and trained staff to provide clinical supervision;						
	2. Records on mentoring and relevant training for undergraduates and postgraduates as determined by the Facility; and						
	3. Memorandum of Understanding.						
CRITERION 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.	1. Letter of appointment – Local Preceptor/ Clinical Instructor; and						
	2. Qualification and training records of local preceptor.						

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STANDARD 27.2.2 (NEW)

The deceased organ and tissue donation services shall be responsible for promoting and supporting the physical, mental and spiritual wellbeing of the deceased organ and tissue donation services staff, ensuring a safe and healthy work environment.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 27.2.2.1 (CORE)							
The deceased organ and tissue donation services shall have policies and procedures for the promotion of staff physical, mental and spiritual well-being. a) A health-promoting environment, e.g., stress management, staff engagement opportunities, workload monitoring, management of work life balance, healthy, lifestyle programmes e.g. Workplace Wellness Programs, Community-Based Health Initiatives; b) Staff shall be provided with appropriate supervision, support, and advice e.g., mentor mentee program; and c) There shall be clear procedures for the effective management of underperformance e.g., feedback on performance review or performance appraisal report.	1. The promotion of staff well-being may involve the following:						
		a. Evidence of a health promoting environment e.g., workplace wellness programme;					
		b. Evidence of proper supervision of staff; and					
		c. Evidence of staff appraisal programme with feedback on underperformance.					

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 27.2.2.2 (CORE)						
The deceased organ and tissue donation services shall establish a safe mechanism for staff to express grievances, provide suggestions and report risk concerns or safety threats anonymously, with assurance of non-retaliation in accordance with the principles of psychological safety.	1. Deceased organ and tissue donation staff suggestions and grievance reporting and processing mechanisms are available;					
	2. The resolution of workplace issues may involve the following:					
	a. Measures and evidence of deceased organ and tissue donation staff protection including whistleblowers against violence, bullying, and harassment e.g., awareness campaigns, anonymous reporting channel, Whistleblower policy; and					
	b. Documented policies and procedures for violence activation and deceased organ and tissue donation staff protection.					
CRITERION 27.2.2.3 (NEW)						
A system shall be created to gather staff feedback about their workplace experience such as burnout which shall be analysed and used to make improvements that enhance the work environment, deceased organ and tissue donation staff satisfaction, and organisation culture.	1. Deceased organ and tissue donation staff feedback (e.g., minutes of sessions or deceased organ and tissue donation staff satisfactions survey):					
	a. Evidence of action or improvement taken.					

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 27.2.2.4 (NEW)							
The deceased organ and tissue donation services shall track sick leave and deceased organ and tissue donation staff turnover, using this data to improve wellbeing, engagement, and retention. Data analysis shall support better workforce planning	1. Workforce data (e.g., sickness absence, early retirements due to ill health, and voluntary resignations) is regularly checked for trends and compared across departments. The results shall be used to create focused actions that improve staff well-being, solve problems, and help retain employees.						

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TOPIC 27.3
POLICIES AND PROCEDURES

STANDARD 27.3.1
DEVELOPMENT, DERIVATION AND DOCUMENTATION
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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 and Patients and Family Rights. 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.	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; and						
	4. The policies and procedures are endorsed and dated.						
CRITERION 27.3.1.2 (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	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; and						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
involved. Cross- departmental collaboration is practiced in developing relevant policies and procedures where applicable.	3. Documented cross departmental policies.						
CRITERION 27.3.1.3							
Current policies and procedures are communicated to all staff.	1. Training and briefing on the current policies and procedures/Minutes of meetings; and						
	2. Circulation list and acknowledgement.						
CRITERION 27.3.1.4 (CORE)							
There is evidence of compliance with policies and procedures.	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; and						
	d. Practices in line with established policies and procedures.						
CRITERION 27.3.1.5							
Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.	1. Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.						

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TOPIC 27.4
FACILITIES AND EQUIPMENT

STANDARD 27.4.1
Appropriate, adequate and safe facilities and equipment are available to enable deceased organ and tissue donation and promotion meets its objectives and goals.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 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.	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; and						
	4. Absence of overcrowding.						
CRITERION 27.4.1.2							
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); and						
	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.						
CRITERION 27.4.1.3 (CORE)							
There is evidence that the Facility has a comprehensive maintenance programme such as	1. Planned Preventive Maintenance records such as schedule, stickers, etc;						

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CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.	2. Planned Replacement Programme where applicable;						
	3. Complaint records; and						
	4. Asset inventory.						
CRITERION 27.4.1.4 (CORE)							
Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.	1. User training records;						
	2. Competency assessment record;						
	3. Letter of authorisation; and						
	4. List of staff trained and authorised to operate specialised equipment.						
CRITERION 27.4.1.5 (NEW)							
The Service shall practice responsible stewardship of the facilities and equipment to promote environmentally sustainable care.	1. Evidence of any initiative or change of practice or policy that promote environmentally sustainable care.						

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TOPIC 27.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 27.5.1
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.

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 27.5.1.1							
The Facilities required to conduct risk assessments that could be relevant to patients/service users and/or staff base on: a) A formal and documented risk assessment process is established and implemented within the organ and tissue donation service; b) Risk assessments are conducted for critical processes such as donor identification, consent procedures, procurement logistics, tissue handling, and communication with next of kin; c) Occupational safety risks to staff (e.g. on-call deployment, travel for retrieval, exposure to biological hazards, fatigue) are assessed and mitigated; d) Risk assessments are integrated into overall quality improvement, patient safety/ Donor care and incident reporting systems; and e) Training staff for risk management.	1. Risk Registry and Management;						
	2. Risk management policy or SOP;						
	3. Occupational risk assessments;						
	4. Integration with incident reports management available: a. Audit or/and reports showing follow-through actions.						
	5. Documented training of staff in risk management.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
CRITERION 27.5.1.2							
There are periodical 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; and g) Innovation.	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; and						
	5. Records on innovation if available.						
CRITERION 27.5.1.3							
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.	1. Minutes of meetings;						
	2. Letter of assignment of responsibilities; and						
	3. Terms of Reference/Job description.						
CRITERION 27.5.1.4							
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	1. System for incident reporting is in place, which include:						
		a. Training of staff;					
		b. Policy on incident reporting;					

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
Analysis done and action taken within the agreed timeframe to prevent recurrence.	c. Methodology of incident reporting; and						
	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; and						
	8. Feedback given to staff regarding incident reporting.						
CRITERION 27.5.1.5							
The Facilities shall oblige to any quality audit processes from either the Facility or relevant regulatory or certifying bodies.	1. Facilities obliges to any quality audit processes from either the Facility or relevant regulatory or certifying bodies by providing audit reports and opportunity for improvement (OFI).						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
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CRITERION 27.5.1.6							
There shall be participation from among Facilities staff in the monitoring and audit processes of the Facility.	1. Evidence of participation among Facilities staff in the monitoring and audit process of the Facility.						
CRITERION 27.5.1.7 (CORE)							
Tracking and trending of the following performance indicator (at least 2); a) Increment rate number of referral to NTRC (>5%) from previous year; b) Brain Death Testing Rate (≥60%) in a year; c) Family Approach Rate for Cardiac death (>60%) in a year ; and 2. Family Approach Rate for Brain Death (> 60%).	1. Specific performance indicators monitored;						
	2. Records on tracking and trending analysis;						
	3. Written document for performance improvement activities; and						
	4. Remedial measures taken where appropriate.						
CRITERION 27.5.1.8							
The Services participates in the Facility's safety culture assessment. The results are utilized by Service leadership to inform and guide efforts to improve the culture of safety within the Service.	1. Safety Culture Survey for staff						
CRITERION 27.5.1.9							
Feedback on results of safety and performance improvement activities are regularly communicated to the staff to promote transparency, shared learning, and active	1. Results on safety and performance improvement activities are accessible to staff through education sessions, meetings and digital communications.						

CRITERIA FOR COMPLIANCE	EVIDENCE OF COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
engagement in improvement initiatives.							
CRITERION 27.5.1.10							
Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patient/ donor and next of kin is preserved.	1. Documentation on performance improvement activities and performance indicators; and						
	2. Policy statement on anonymity on patients and providers involved in performance improvement activities.						
CRITERION 27.5.1.11							
Facilities 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.	1. Documentation on Emergency / Contingency Plan; and						
	2. Documented of Facilities staff responsibilities during emergency/disaster.						

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SERVICE SUMMARY	
OVERALL RATING :	-
OVERALL RISK :	-

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