HOSPITAL KULIM

WHOLE HOSPITAL POLICY

APPROVED BY;

[Signature]

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1 PREAMBLE

Hospital Kulim is situated on a 60 acres site within a Hi-Tech Industrial area has been providing services since 1994. It is a replacement hospital for the old medical facility built in 1912. Hospital Kulim is located only 5 km from the town center and is easily accessible. It serves a population of 350,000 within two (2) districts in the state. The hospital receives referred cases from ten (10) public health centers, 36 community clinics, 56 general practitioner clinics and seven (7) private dialysis centers. The main referral hospitals are the state hospital, located 120 km to the north and the regional hospital, about 40 km to the west.

The hospital has 350 beds. Hospital Kulim is well-equipped to provide specialist services. Specialist services currently being provided include General Medicine, General Surgery, Obstetrics & Gynecology, Pediatrics, Orthopedics, Anesthesiology, Otorhinolaryngology, Ophthalmology, Oral Maxillofacial Surgery & Dental and Nephrology. 24 hours Emergency Services are also provided. The clinical diagnostic and support services available are Pathology & Blood Transfusion, Radiology & Diagnostic Imaging, Pharmacy and several allied health services.

The main physical structure of the hospital consists of 2 storey building which housed the wards, treatment facilities, clinics, operation theatres, offices and the support services.

2 DIRECTIONS

2.1 Vision

To provide quality medical services for all

2.2 Mission

To promote wellness and deliver high quality medical care to our patients through a team of professional, team work and caring work force together with private sector, non-government organization, public and individual.

2.3 Objective

To improve the quality of patient care through effective and efficient diagnostic, curative and rehabilitate medical services with the intention of saving lives and reduce pain and faster recovery in a short period of time.

3 HOSPITAL MANAGEMENT

3.1 Management structure

i. The hospital is headed by a hospital director. He / she are supported by 3 deputy directors and heads of the departments and units.
ii. The hospital director shall be responsible for the overall management of the hospital. He or she shall provide direction, advice and guidance to the staff and makes decisions on resource allocation.

iii. The department and unit shall be headed by specialists or officers trained in their respective discipline. All heads of departments and units shall be responsible and accountable for the service provision and the efficient management of resources allocated to the department / unit.

iv. An officer shall be appointed to be in charge of certain specific areas or to coordinate certain activities or programs in the hospital. Such officer shall report either directly to the director or any officer appointed by the director or to the relevant committee. The organizational structure is shown in appendix 1.

3.2 Committees

i. The hospital shall establish a Management Committee, a Medical Advisory Committee and several other committees as required by the Ministry of Health or the Central Agency.

ii. A management committee chaired by the director shall discuss management issues and makes decision on resource allocation and distribution.

iii. Clinical matters shall be discussed at the Medical Advisory Committee chaired by the specialists.

iv. Other committees shall be headed by the director or an officer appointed by the director. The members shall consist of officers from relevant departments and units. Each committee shall have its own terms of reference. List of the committees is as shown in appendix 2.

3.3 Board of Visitors

i. The hospital shall establish a Board of Visitors as required by the Ministry of Health (MOH).

ii. The Board of Visitors shall act as a link between the hospital and the community.

iii. The Board members shall be appointed by the Ministry of Health. Appointed members shall be provided with an identification card.

iv. The Board members shall be briefed on the hospital organizational structure and services, the rules and regulations and the Board of Visitors roles and responsibilities.

v. Board members shall be allowed to make visits to the wards and other public areas during or after office hours. The hospital management shall take appropriate actions on the feedback received or issues raised by the Board.

vi. Board members shall be invited to attend hospital functions and activities including the relevant CME session.
4 MEDICAL FACILITIES

An officer shall be appointed to manage the day to day running of each medical facility and ward.

4.1 Specialist Clinics

i. The clinics shall be used to provide specialist outpatient care.

ii. The specialist clinic services provided are Medicine, Surgery, Orthopedics, Obstetrics & Gynecology, Pediatric, Ophthalmology, Otorhinolaryngology, Psychiatry, Oral Maxillofacial and Nephrology.

iii. The consultation & examination rooms shall be commonly shared as and when necessary.

iv. Clinics shall be opened during office hours on working days according to the respective clinic schedule.

4.2 Emergency department

i. The emergency department shall be used to provide emergency care to patients brought in or referred to the hospital.

ii. The department shall have designated areas or zones for management of patients according to the severity of illness.

4.3 Ambulatory care services

i. The ambulatory care services is provided by the respective department:
   a. Medical
   b. Surgical
   c. Pediatric

ii. Hospital does not provide a commonly shared area/special area. The services are provided by the respective department at their own discipline/designated area.

4.4 General ward/beds

i. This hospital has a total of 350 inpatient beds.

ii. The distribution of wards by disciplines are as follows,

   - Medical/Nephrology - (3 wards)
   - Surgical - (1 ward)
   - Orthopedics/Eye/ENT/Dental/Psychiatry - (2 wards)
   - O&G - (2 wards)
   - Pediatrics - (2 wards)
iii. Male and female patients shall be placed in separate rooms or cubicles in the ward.

iv. The general wards shall be opened to the public during visiting hours. After visiting hours, access to the ward shall be restricted to those who have a special pass.

v. A bed manager shall be appointed to coordinate and ensure optimal bed utilization.

4.5 Special wards/beds

i. The special wards and beds are as follows:

- Intensive care unit (ICU) - 8 beds
- Coronary care unit (CCU) - 4 beds
- Special care nursery (SCN) - 30 beds
- Neonatal intensive care unit (NICU) - 6 beds

ii. The ICUs shall be under the responsibility of an anesthetist, the CCU under the responsibility of a physician, and the SCN including the neonatal intensive care unit (NICU) under the responsibility of a pediatrician.

iii. The beds in ICUs shall be commonly used by all clinical disciplines.

iv. Public access to the critical ward shall be restricted at all times to only those with special pass.

4.6 Other beds

i. There are beds located in other areas and used for specific purpose. These beds are not included in the total hospital bed count. Examples are,

- Observation ward (ED) - 8 beds
- Maternity assessment center - 1 beds
- Labour delivery suites - 8 beds

4.7 Operation theatres

i. There are 2 major operation rooms and 1 minor operation room

ii. The operation rooms shall be utilized for procedures and surgeries which require to be performed under sterile condition.

iii. Access to the operation theatre shall be restricted to reduce the risk of cross infection.

iv. Person entering the operation theatre shall be required to wear the proper attire provided in the theatre and shall be subjected to the rules and regulation in the theatre.
v. The work flow and processes in the operating theatre shall abide to the infection control procedures.

4.8 Other treatment facilities

Hemodialysis Unit

i. The hemodialysis unit is situated at old hospital. It has 22 hemodialysis machines. The utilization of hemodialysis machines shall be as follows:

- general use - 10 in use + 2 standby
- infectious cases - 6 (1 Hepatitis C, 1 red tag for infectious case, 4 green tags- ward use for acute case)

(Note: there are 2 separate hemodialysis machine, 1 CVVH, and 1 SLED machines in hospital kulim which is situated in ICU – for patient requires emergency hemodialysis)

Labour delivery suites

i. The 10 labour delivery suites shall be used for all deliveries other than caesarian section.

ii. In line with the policy on husband friendly, patient’s husband shall be allowed to accompany patient during delivery.

iii. In line with the policy of mother friendly, patient are allowed to have companion of their choice, consider the use of non drug method of pain relief.

Observation wards (ED)

i. Observation ward shall be utilized by the Emergency Department to admit patient requiring temporary observation.

5 MEDICAL SERVICES

5.1 Pre-hospital and emergency services

i. The hospital shall provide pre-hospital and hospital emergency services on 24-hour basis. The services shall be under the responsibility of the head of the emergency department.

ii. The department shall be responsible for the provision of emergency care to patients to save lives, preserve body functions and prevent complications.

iii. During a disaster, the department shall play a lead role in the management and treatment of the victims on site and in the hospital.

iv. Stand by medical cover shall be provided on request subject to the availability of staff and the policy and procedures from the MOH.
5.2 Specialist services

i. The hospital shall provide specialist services in various clinical disciplines as listed below.

- General medicine
- Nephrology
- General surgery
- Obstetric & gynecology
- Pediatric
- Orthopedics
- Anesthesia
- Ophthalmology
- Otorhinolaryngology
- Psychiatry
- OMF (Surgery & Maxillofacial and Oral medicine)

ii. The specialist services shall be headed by senior specialists appointed by the Hospital Director. The head shall be responsible for managing the department, utilization of resources and delivery of quality services.

iii. Specialist services shall be provided as inpatient, outpatient and on day care basis. Scope of services provided shall be determined by the respective departments based on the availability of equipment and trained personnel.

iv. Attendances to specialist outpatient clinics are by referral and appointment. The respective department shall determine the clinic schedule, the appointment system and patient management at the clinic.

v. For day care/day surgery services, the department shall determine the scope or list of day care procedures/surgeries, the criteria for patient selection, the appointment scheduling and patient management before, during and after the treatment / procedures.

vi. The inpatient services shall be provided on 24 hours basis. After office hours, admissions and emergencies shall be attended to by the respective doctor and specialist on call.

vii. The head of department shall ensure proper documentation of patient’s medical records, collection and compilation of statistics.

viii. The head of department shall be responsible for the continuous professional development of its staff.

ix. The department shall also be responsible for the credentialing and privileging of staff to carry out special procedures.
5.3 Diagnostic services

i. The following diagnostic services shall be provided,
   - Pathology
   - Diagnostic imaging

ii. The services shall be headed by the respective specialists appointed by the Ministry.

iii. The services shall be available during office hours. After office hours, emergency request shall be attended to by a staff on call.

iv. Scope of services provided shall be determined by the respective departments based on the availability of equipment and trained personnel.

v. Request for diagnostic services shall be made by a doctor using the standard forms (for external patients). Special investigations or procedures shall be requested by a specialist.

vi. The Diagnostic Imaging services shall include some interventional radiological services. All CT scan done by Emergency Department must be reviewed by Emergency Department Physician prior to admission or discharge of patients.

vii. The Pathology services shall include Biochemistry (include special protein lab), Medical Microbiology, Hematology, and blood donor transfusion services.

viii. Forensic services shall include the management of dead bodies before handing over to the relatives, and post mortem if there is a legal or clinical requirement. Post mortem for medico-legal case shall be carried out by a medical officer.

5.4 Allied health and clinical support services

i. The following services shall be provided,
   - Physiotherapy
   - Occupational therapy
   - Medical social work
   - Dietetic counseling
   - Health education
   - Unit Keselamatan Dan Kesihatan Pekerjaan.

ii. Each service shall be headed by a trained and qualified person. The head shall be responsible for the delivery of services and efficient management of resources.

iii. The services shall be provided during office hours. After office hours, services may be provided when there is an urgent need.
iv. Scope of services provided shall be determined by the respective department/unit heads based on the availability of equipment and trained personnel.

v. The services shall be provided to outpatient and inpatient referred by a doctor.

vi. Field investigative and support service may be provided to patients at their home when there is a need.

5.5 Haemodialysis service

i. Haemodialysis service shall be provided to inpatient and outpatient.

ii. Management of patient on hemodialysis shall be under the responsibility of the Medical Department / Nephrologist.

6 PATIENT MANAGEMENT

6.1 Appointment and scheduling

i. Patient referred to the specialist clinic shall be given an appointment date in the same specialty.

ii. For urgent appointment, the referring doctor shall be required to consult the specialist/medical officer of the respective discipline before referring the patient. Patient may be given an early appointment or arrangement made for the patient to be seen on the same day.

6.2 Registration

i. All patients receiving care in the hospital shall be registered at the central registration counter. Patients shall be required to bring personal identification document, guarantee letter from the employer and other relevant documents. Non-Malaysians are required to produce valid travel documents.

ii. Patient particulars which include the home address, contact number and the particulars of the next-of-kin such as the name and contact number shall be collected on registration.

iii. For new patients, a medical record number shall be given and the medical record created for the patient.

iv. Fees or deposit shall be payable at the registration counter.

v. Registration of all admissions shall be carried out at the Admission and Revenue Unit.

vi. All first time registered patients shall be given an appointment card.
6.3 Patient management in Specialist Clinic

i. Patient shall be seen and examined by a specialist or trained medical officer/ House officer under supervision.

ii. Investigations and procedures carried out in the clinic shall be confined to those which can be done immediately and not requiring a period of observation. The findings shall be documented in the medical record.

iii. Investigation and procedures shall be ordered by doctors or authorized personnel.

iv. Details of the clinic consultation shall be documented in the medical record.

v. At the end of clinic session, patient may be either discharged, given another clinic appointment, referred elsewhere or admitted in Day Care/Wards for investigations/procedures.

6.4 Patient management in Emergency Department

i. All emergency cases shall be seen and managed in the Emergency department.

ii. Patients shall be triaged and managed according to the severity of illness.

iii. Critically ill patients shall be managed at red zone, semi-critical patients at yellow zone and non critical patient at green zone.

iv. Doctors in the emergency department shall examine patient and provide immediate care to save life and prevent complications.

v. If necessary, the respective doctors on call for ill cases shall be informed as soon as the patient illness and clinical discipline are known.

vi. Patients shall be seen by the doctor on call of respective discipline on priority base. The emergency department doctors shall decide on admission if patient is not seen within the half hour.

vii. Patients may be admitted to the observation ward for temporary observation.

6.5 Admission

i. All admissions shall be initiated by a doctor.

ii. Patients shall be informed of the reason for admission and the proposed care plan by the admitting doctor.

iii. Patients for elective admission shall be given an admission slip which contains information regarding the date and time of admission, what documents to bring and telephone number of a person to contact and the respective procedure instruction.
iv. Patient shall be advised not to bring valuable items to the hospital.

v. Patients for elective surgery shall be instructed to come for admission during office hours.

vi. Ill patients shall be transferred to the ward accompanied by appropriate medical personnel.

vii. Admission of patients with multiple injuries or disease conditions shall be determined by the multidisciplinary care team members through a consensus. In conflicting situation where consensus cannot be reached in an acceptable time frame, privilege shall be given to the emergency department doctor to decide the primary care team putting the best interest of the patient first.

6.6 Ward stay

i. An identification wristband shall be provided to all inpatients. All inpatients shall be required to wear an identification wristband all the time during the hospital stay.

ii. Assigned of bed shall be done by the respective ward nurse.

iii. Nurse shall inform the doctors within 15 minutes for new admitted patient.

iv. Individual patient shall be provided with a bed, chair and a locker. Facilities like toilet, bath and rest area shall be shared.

v. Patient shall be provided with the hospital clothes to wear.

vi. Patients shall be given a ward orientation and be informed about the rules and regulations in the hospital. They shall be informed that the ward staff shall not be responsible for any loss of valuable items. Patients/their family shall also be informed about their rights and responsibilities while in the hospital.

6.7 Patient examination

i. Ill patients shall be given priority to be seen and examined early.

ii. Patient’s privacy shall be protected during any physical examination.

iii. A chaperone shall be present when a patient is being examined by a staff of the opposite gender.

iv. Patient shall be attended to by a Doctor within an hour of admission. Ill patients shall be attended to by a Doctor immediately.

v. Inpatients shall be seen by a doctor at least once daily and before discharge.
vi. Patient shall be seen by a specialist at least once in 24 hours after admission. In critical care areas the specialist shall see the patients at least once a day.

vii. Grand ward round shall be conducted by each discipline at least once a week (as required/ as necessary)

viii. Findings of an examination shall be documented in the patient’s electronic medical record.

6.8 Consent

Every patient has a choice whether or not to undergo a proposed procedure, surgery, treatment or examination. Informed consent usually refers to the idea that a person must be fully informed and understand of the potential benefits and risks of their choice of treatment. An uninformed person is at risk of mistakenly making a choice not reflective of his or her values or wishes.

i. Obtaining a patient’s consent is a specific legal requirement and is part of good medical practice.

ii. Consent shall be obtained from the patient or next-of-kin prior to carrying out any clinical procedures. Consent shall be obtained from the patient if he / she is 18 years old or more, physically and mentally competence.

iii. In live-saving situation where all efforts to trace relatives and next-of-kin have failed, two clinical specialists, one of whom is from the related discipline can give consent for the procedure to be carried out. In the absence of the second specialist, the Pengarah shall be the signatory. The consent and efforts made to trace the relatives/ next-of-kin shall be documented in the case notes.

iv. All consent must be taken by a medical officer or specialist performing procedure using the consent/appropriate form. The communication includes but not restricted to:

- Patient’s condition
- Proposed treatment/procedure
- Potential benefits and risks
- Likelihood of success/failure
- Possible alternatives
- Possible problems related to recovery
- Possible results of non treatment

v. For patients below the age of 18 or patient of unsound mind consent shall be obtained from the legal guardian.

vi. Consent shall also be obtained from the patient or next-of-kin when body parts or organ are taken for academic or research use.
vii. For a mentally disordered patient who is required to undergo surgery, electroconvulsive therapy or clinical trials, consent for any of them may be given by:-

- The patient himself if he is capable of giving consent as assessed by a psychiatrist
- His guardian in the case of a minor or a relative in the case of an adult, if the patient is incapable of giving consent
- Two psychiatrists, one of whom shall be the attending psychiatrist, if there is no guardian or relative of the patient or traceable and the patient himself is incapable of giving consent

viii. For a patient below the age of 18 who required a medical treatment, consent shall be obtained as below:-

- If, in the opinion of medical officer, the patient requires surgery or psychiatric treatment due to serious illness, injury or condition, the consent shall be given by the parents/guardian of the child/any persons having authority to consent for the treatment
- If, the medical officer has certified in writing that there is an immediate risk to the health of a child and medical/surgical/psychiatry treatment is necessary, a Protector may authorize without obtaining the consent from the parents/guardian of the child/any persons having the authority, but only under any of the following circumstances:-
  1) That the parents/guardian of the child/any persons having the authority to consent to the treatment has unreasonably refuse to give, or abstained from giving consent to such treatment
  2) That the parents/guardian of the child/any persons having the authority to consent is not available or cannot be found within a reasonable time
  3) The Protector believes on reasonable grounds that the parents/guardian the authorized person has ill-treated, neglected, abandoned or exposed, or sexually abused the child. (According to Child Act 2001, Protector is defined as the Director General, the Deputy Director General, a Divisional Director of Social Welfare, Department or Social Welfare, the State Director of Social Welfare of each of the State, any Social Welfare officer appointed………..

6.9 Procedures /surgeries

i. Patient shall be informed of any procedures /surgeries that need to be done on him/her.

ii. Procedures /surgeries shall be carried out by medical trained personnel. The relevant department shall determine type of procedures performed by the staff.
iii. Cancellation of elective procedures or surgery shall be avoided unless for valid reason. Patient shall be informed of any cancellation or postponement.

iv. The respective ward shall be responsible for the transfer of patient to and from the operating theatre. Patient shall be transferred on trolley by porters and accompanied by the medical personnel. Beds and wheelchairs may be used when appropriate.

6.10 Referral

i. Referral of patients between hospitals can occur from a lower to higher level of care, higher to lower level of care and also at the same level of care depending on the needs of the patients and / or the providers of care.

ii. Interdepartmental in-patient referrals shall be seen and reviewed in the patients’ wards of origin. They shall be seen in the specialist clinic only where appropriate.

iii. Emergency referrals shall be seen immediately. Non-emergency referrals shall be made only during office hours and seen within the same day of the referral.

iv. Inter-departmental outpatient referrals shall be scheduled with consultation of the respective clinics.

v. Referral shall be ideally from specialist-to-specialist and from medical officer to medical officer. Patient may be referred to allied health professionals for further management.

vi. Referral to other government hospital must be preceded by phone call(s) to the receiving unit(s) before the patient leaves the hospital. Patient shall be stabilized before being transported to another hospital.

vii. For Interdepartmental referrals, the referral letter shall be created by the specialist or by the medical officers.

viii. Emergency referrals from other hospital shall be directed to the Emergency Department for stabilization. If necessary, patient shall be reviewed by the doctor from the respective department/ward in the emergency department.

ix. With the exception of the above policy pre-arranged emergency referrals for certain cases e.g., neonatal jaundice and shall be admitted directly to the respective ward. The registration as per the registration policy.

x. Non-emergency outpatient referrals shall be given an appointment date to come to the Specialist Clinics.

xi. The referring doctor shall consult the doctor in the clinic if a patient needs to be seen on the same day or be given an early appointment.
6.11 Transfer

6.11.1 General

i. Transfer of patients may occur routinely or as part of a regionalized plan to provide optimal care for patients at more appropriate and/or specialized facilities.

ii. Transfer of patient between wards/discipline shall be on the approval of the attending doctor.

iii. Patients shall be accompanied and the referring ward/discipline shall be responsible for the care of the patient during the transfer.

6.11.2 Intra facility Transfer

i. All unstable patients shall be accompanied by trained personnel during transfer.

ii. All patients requiring assisted ventilation from Emergency Department may be admitted directly to critical care ward after consultation between the specialist and anesthetist-in-charge of the critical care ward.

6.11.3 Inter Facility Transfer

i. Patient transfer is a doctor-to-doctor referral. House Officers are not allowed to refer or accept cases.

ii. The decision to transfer a patient for higher level care shall be made upon consultation with the specialist concerned.

iii. The referring medical officer/specialist must contact the relevant medical officer/specialist at the receiving hospital to discuss with on the necessity of transferring the patient and medical doctor/specialist must agree to accept the patient prior to the transfer taking place.

iv. If the referral is indicated but is not accepted by the doctor/specialist (of the receiving hospital), the referring doctor shall inform his/her superior (specialist/Hospital Director). The doctor/specialist who refuses the referral also to inform his/her superior (specialist/Head of Department/Hospital Director) and to document the reason/reason.

v. The patient’s next-of-kin shall be informed about the process of transfer. In emergency situations when a patient is unable to agree to transfer, and the next-of-kin are not contactable, the police shall be informed to help in contacting them. The responsibility for transfer rests with the doctor/specialist in charge of the patient and the consent of the relatives is not always required.

vi. All patients shall be stabilized and deemed stable before transfer.
vii. The staff accompanying referred cases shall be decided by the medical officer or specialist in charge, after consultation with the receiving hospital.

viii. All critical patients shall be accompanied by paramedics trained in resuscitation and headed by a medical officer. Accompanying staff for other cases shall be decided by the specialist/medical officer in charge based upon the clinical condition of the patients. Monitoring of patients shall be done based on the clinical condition of the patient and recorded accordingly.

ix. Documents pertaining to patient’s condition shall be made available to facilitate the transfer. This includes a referral letter with detail history of the patient and reason for referral. All related radiological images and other investigation results (e.g. blood results) should be included.

tax. A patient may be referred to the Emergency Department or directly to the appropriate ward/care unit. The accompanying team shall have clear instructions as to their exact destination (e.g. which ward to go) prior to arrival at the receiving hospital to avoid delay.

xi. The accompanying team shall not leave the patient until the receiving team has formally taken over care of the patient.

xii. If patient’s clinical condition deteriorate during the transfer and resuscitation is required, the ambulance may en route to the nearest health facility or directed immediately to the Emergency Department of the receiving hospital.

xiii. If death occurs during transfer, it shall be certified by a medical officer and the body shall be brought back to the referring hospital.


6.12 Documentation of Clinical Care

i. Clinical management of all patients shall be recorded and documented in the outpatient card, case notes or computerized system and shall be updated upon completion of examination by the attending hospital personnel.

ii. All documents related to patient management including laboratory results, X-Rays, nursing care plan, observation charts, etc. shall be compiled along with the case notes and kept current.

iii. Documentation of clinical care shall be maintained by the hospital personnel attending to the patient and each entry shall be dated, initiated and stamped.

iv. All amendments made must be clearly cancelled and initialed by the respective Hospital personnel. Entries shall not be deleted by corrective fluid.
v. Patient’s file shall be sent to the Record Office within 72 hours after discharge.


6.13 Discharge

Planned discharge:

i. Patients shall be informed in advance of their discharge. Where appropriate, the next-of-kin shall also be notified. Discharge Advise shall be created by doctor.

ii. Discharge shall not be completed until the patient has physically vacated the bed.

iii. Identification wristbands shall be removed at discharge except for newborn and paediatrics cases.

iv. Ward nurse shall ensure only parents/guardians are allowed to take discharged children home.

v. Only parents are allowed to take home discharged babies/newborns. Fathers are required to bring the mothers’ Identification Card and Antenatal Card before they are allowed to take home discharged babies/newborns.

vi. All patient deemed fit for discharge shall be provided with a prescription and relevant information about their medication prior to discharge.

vii. A diagnosis shall be made before a patient is discharged. Doctors have to complete the discharge summary within 72 hours of discharge.


ix. Citizens (Patient) who are unable to settle their bill due to financial reason will be referred to the Medical Social Department/ revenue unit/ hospital administration. Identification

Discharge Against Medical Advice (DAMA):

i. Patient who request for discharge against medical advice shall be required to sign in the DAMA form. Patients or next-of-kin requesting such discharge shall be fully informed of the consequent risks by the attending doctors/ specialists.

ii. The AOR discharge form has to be completed by the medical officer in charge and signed by the patient / relatives / guardian and witness.
iii. AOR for infection disease in adult are not allowed as required in Akta Penyakit Berjangkit.

iv. AOR discharge for paediatric patients must involve Pegawai Kebajikan Masyarakat.

v. On discharge (including AOR discharge), patients shall be provided with relevant documents related to their admission, follow up and further management e.g. discharge notes, medical certificate, appointment card, etc.

vi. Refer to: SPKPK Bil.11/2013 Prosedur Mengenai pesakit yang ingin discaj dari Hospital atas Risiko Sendiri.

Absconded:

i. Patient shall not be allowed to leave the ward without permission. Those leaving the ward without permission shall be declared as ‘absconded’.

ii. If a patient is found to be missing from the ward / bed, all efforts shall be made to locate him / her within the vicinity of the Hospital. The ward staff shall notify the next-of-kin and the police if the patient is still missing within 1 hour of search.

iii. Patient found missing and do not return within 24 hours shall be discharged from the ward. An incident report must be prepared for such cases.

6.14 Death

i. The attending doctor in the ward or the emergency department shall carry out confirmation of death.

ii. On confirming death, the ward/department staff shall verify the deceased status as organ donor, conduct the last office, and notify the mortuary and the next-of-kin. If the next of kin is not contactable, the police shall be notified.

iii. Patients brought in dead shall be examined and the death confirmed by the doctor in the emergency department. Proper documentation shall be made in the medical record.

iv. All dead bodies shall be transferred to the mortuary not more than 1 hour after the confirmation of death.

v. All deaths in the hospital shall be registered at the mortuary. Dead bodies shall be released to the next of kin or authorised person through the mortuary. All information on body release shall be well documented.

vi. In the case of referred patient, the hospital shall be responsible for the transfer back of the dead body to the referring government hospital.
vii. Dead body brought to the hospital by the police for post mortem shall be sent directly to the mortuary.

viii. Post mortem for medico-legal cases shall be performed by the forensic Pathologist or a medical officer. Post mortem for motor vehicle accident (MVA) cases shall be done by a medical officer from the Forensic Department.

ix. For clinical post mortem, the requesting clinician shall get a written consent from the next-of-kin and the post mortem done by forensic pathologist.

x. Body of the deceased shall be stored in the mortuary freezer prior to being claimed by the family.

xi. Unclaimed bodies shall be notified to the police and notices placed in newspaper after 3 days (muslim) and 14 days (non-muslim). The body shall be handed over to the respective religious body for burial or cremation if no claim is made after 3 days (muslim) and 14 days (non-muslim) following notification.

xii. For unclaimed bodies of non-citizen, the respective embassies shall be notified of the death.

xiii. Management and handling of infectious dead bodies shall be in accordance to the standard procedures to prevent cross infection. The Health Inspector in the District Health Office shall be notified.

**Epidemic Management**

i. Policy as per MOH.

7 **DRUGS AND MEDICATION**

7.1 **Usage**

i. Hospital drug formulary shall be maintained and used as a guide for drug prescription.

ii. Prescription and supply of drugs not listed in the Hospital drug formulary but available in the Ministry drug formulary (blue book) shall require the specialist or head of department’s request to the Pharmacy Department and subsequent decision at the Hospital Drug Committee Meeting.

iii. Prescription and supply of drugs not listed in the Ministry drug formulary (blue book) shall require the Ministry’s approval.

iv. The respective head of the department shall be responsible for the justifications of the drug usage and cost implication.
v. The request shall be made using the specified format and submitted through the Pharmacy Department.

7.2 Prescription

i. Doctors shall prescribe drugs to only registered patients. Prescription shall be manually written for specific circumstances.

ii. Valid prescription referred by the pharmacy department from other Ministry of Health hospitals and clinics shall be accepted.

iii. Prescription from IJN shall be endorsed once by the hospital specialist before prescription is filled, subject to availability of drugs.

iv. Prescription from the private sector shall not be accepted.

v. Patient shall be required to collect their medicines within one week of the date of prescription. Uncollected medicines after one week and any expired prescription shall not be dispensed.

vi. Term prescription (more than 1 month) shall be filled in at specified intervals.

7.3 Dispensing

i. Drugs shall be dispensed at the specified pharmacy counter.

ii. Dispensing of drugs to patients shall be done during office hours except for patients in the emergency department.

iii. Drug counselling shall be provided to individual patients based on needs.

iv. Urgent needs for inpatients shall be met by the pharmacy personnel on call.

7.4 Monitoring

i. Usage of drugs, drug prescription and drug reaction shall be monitored by the pharmacy department.

ii. Drug committee shall be established to coordinate, monitor and manage all issues relating to drugs and drug usage.
8 EQUIPMENT & PHARMACEUTICAL SUPPLY

8.1 Requirement & Specification

i. Requirement of medical equipment, consumables, drugs and pharmaceutical supplies shall be decided by the individual department/unit and coordinated by the pharmacy department.

ii. The respective head of the department shall be responsible for preparing the technical specifications.

8.2 Delivery & Supply

i. Standard items shall be stored for 2-3 months supply and non-standard item shall be made available only on request.

ii. All pharmaceutical supplies shall be delivered to the Pharmacy logistic Unit @medical store except for chemical reagent, which shall be sent directly to Pathology department. The supply for consumables shall be direct from Pharmacy Logistic Unit and the supply for drugs shall be from the ward supply pharmacy.

iii. Bulky equipment’s shall be delivered directly to the respective end user. The Store personnel shall be present to verify the delivery.

iv. Head of department shall be responsible to verify the contents, ensure compliance to the specifications and carry out testing and commissioning before signing any acceptance forms. Submission of all documents to the pharmacy department shall be completed within two weeks of delivery.

v. Dangerous and Psychotropic Drugs shall be collected from the Ward Supply Pharmacy by authorised staff, stored and transported under lock and key, and managed only by authorised staff.

vi. Items requiring cold storage (temperature 2-8°C) and inflammable/ explosive materials shall be kept in individual storage area.

vii. Department attendants/auxiliary staff shall be responsible for all collection of supplies.

8.3 Inventory list

i. The administration unit shall maintain an up to date inventory list of the hospital. The department and unit shall also maintain an inventory list of equipment within the department and unit.

ii. Equipment shall not be moved or transferred to another department or another hospital without prior approval of the Hospital Director.
8.4 Disposal

i. Head of department shall be responsible to submit a list of equipment to be condemned to the Finance and Account Unit.

ii. Equipment which has been given the certificate of ‘beyond economic repair’ shall be disposed off accordingly.

9 STERILISATION AND DISINFECTION

9.1 General

i. The Sterile Supply Unit shall be overall responsible for the sterilization and disinfection services in the hospital.

ii. Sterilization and disinfections of equipment and items shall be carried out using the appropriate and accepted technique or method.

iii. Staff involved in the sterilization process shall follow the standard procedures to ensure the sterility of the product.

iv. Staff shall wear proper attire for safety protection against infection and other hazards.

9.2 Surgical sets

i. Sterilization of surgical sets shall be carried out by the Sterile Supply Unit.

ii. Sterile surgical sets shall be properly sealed and the sterilization date clearly written.

iii. Clean and sterile surgical sets shall be supplied to the wards and clinics according to the requirement and schedule.

iv. The department/unit shall be responsible for proper handling and storing of the sterile sets.

v. Sets shall not be used if there is any damage to the wrapper.

vi. Used surgical sets shall be sent to the Sterile Supply Unit for sterilization.

vii. For high-risk patient, such as known case of HIV/AIDS and Hepatitis B, disposable sets shall be used.
9.3 Linen and soft dressing

i. Linen shall be washed first by the Concession Company and the clean linen sent to the Sterile Supply Unit for sterilization.

ii. Soft dressing shall be pre-packed and sterilized centrally.

9.4 Special / delicate equipment

i. Delicate equipment shall be sterilized centrally. Staff shall be trained to handle such equipment.

ii. Endoscopes shall be sterilized locally using high level disinfectant.

9.5 Infection Control

i. Hospital Infection Control Committee shall be established to monitor and coordinate all activities related to infection control. Issues pertaining to hospital infection shall be presented to the Committee for further action.

ii. An infection control coordinator shall be appointed. The coordinator together with the liaison officer (link nurse/staff) from each area/ward shall form the infection control team.

iii. The team shall monitor the implementation of infection control procedures, carry out surveillance activities, monitor antibiotic resistance pattern and conduct training of hospital staff.

iv. Infectious patients shall be placed and and nursed in single rooms wherever possible. The use of multi – bedded rooms for the same type of infection is acceptable.

v. Staff shall be instructed to adhere to barrier nursing and standard precaution guidelines all the time. This includes frequent hand washing and the use of gowns by those having direct contact with an infectious patient.

vi. All instruments and linen used by infectious patients shall be placed in special bags (without washing or soaking).

vii. All clinical waste from infectious patients shall be double-bagged in yellow plastic bags for disposal by incineration. Management of the clinical waste shall be as stipulated in the privatization contract.

10 FOOD AND CATERING

10.1 General

i. Food handlers in the hospital kitchen and cafeteria shall be subjected to the rules and regulations on food safety and hygiene.

ii. Food handlers shall use glove and wear proper attire to minimize food contamination.

iii. Cooked food shall not be left exposed or uncovered for a long time.

iv. Hawkers shall not be allowed to sell food within the hospital compound.

10.2 Hospital food

i. Dietetic and Catering Department shall be responsible for the overall monitoring of the services.

ii. Hospital shall provide food to inpatients, patients on daycare and patients in observation ward, mother accompanying child and doctors on call.

iii. Inpatients shall be provided with 4 meals.

iv. Food shall be tested before serving to patients.

v. The ward staff shall be responsible for placing orders of food and for making changes in the order.

vi. Food shall be served in the ward on individual plates at specified time.

vii. Supply of enteral nutrition products, infant formula and dry ration products to the ward for selected inpatient shall be under the responsibility of the Dietetic and Catering Department.

11 MEDICAL RECORD AND INFORMATION

11.1 Patient Registers

i. Patients shall be given only one medical record number for personal identification. The registration number shall be used in all forms /documents pertaining to the care of the patient.

ii. Registration format shall be as specified by the Ministry or the hospital.

iii. The staff at the registration counter shall be responsible for ensuring the completeness of the data.
11.2 Medical records
i. Every patient receiving care in the hospital shall have his/her own medical record.

ii. Care given and procedures done on a patient shall be documented in the patient’s medical record. The attending doctor shall be responsible for proper documentation and legibility of the notes in the record.

iii. Hospital shall implement an integrated medical record system where all care providers document their notes on the same medical record and in chronological order.

iv. All case notes and treatment records of a patient shall be compiled as one medical record and kept in a single folder.

v. Referral letter and other documents relating to the care shall be kept together with the patient’s medical record.

vi. Management of medical records shall be under the responsibility of the Medical Record Unit. The records shall be managed to ensure safety, confidentiality and fast retrieval.

vii. A medical record committee shall be established to coordinate all issues pertaining to medical record services.

viii. All personnel involved in the handling of medical records shall be responsible for maintaining the confidentiality and safety of the records.

11.3 Medical statistics
i. Data and statistics to be collected shall be as specified by the Ministry or the Medical Record Committee of the hospital.

ii. The respective department and unit shall submit data to the medical record unit within the specified time.

iii. Release of medical data and statistics of the hospital shall be done through the medical record unit and subject to the director’s approval.

11.4 Medical reports
i. Medical report shall be prepared on receiving written request from the patient or authorized person.

ii. Medical report shall be prepared by a doctor or if requested, by the specialist in the respective discipline involved in the care. The report shall be prepared within a specified time.

iii. Medical report of medico-legal or potential medico-legal cases shall be released on Ministry’s approval.
iv. Medical report shall be charged in accordance to the Fees Act 1982 / its amendment / Ministries circulars.

11.5 Ethics and Law

The hospital shall abide by the laws of the country, policies and guidelines of the Ministry of Health, medical ethics and relevant policies and guidelines of other Ministries. Legislations, regulations, policies and guidelines may be amended by the relevant authorities as and when necessary.

11.6 Organ and Tissue Donations

11.6.1 The Hospital Management shall establish an organ procurement team and a mechanism to support the choice of patients and families to donate organs and tissues for research / transplantation.

11.6.2 Designated staff is trained for the procurement, banking, and transportation or transplantation process.

11.6.3 Policies and procedures shall be made available to guide the procurement, donation process and transplantation of organs and tissues. They are consistent with the relevant laws and regulations and respect the community values, spiritual beliefs and religion (MOH – national Organ, Tissue and Cell Transplantation Policy, 2007).

12 INFORMATION TECHNOLOGY

12.1 Utilization

i. The Information Technology Unit shall be responsible for the overall monitoring and coordination of ICT utilization.

ii. ICT shall be used to facilitate communication and information sharing.

iii. The respective department and unit shall be responsible for the change in the work process and the end-user training.

12.2 Security

i. For security and confidentiality, the hospital shall determine the access level of each staff to the IT system and medical records.

ii. Staff shall be provided with their own password. The staff shall be responsible to protect and safeguard their password against wrong usage.
13 COMMUNICATION

13.1 Staff communication

i. Telephone lines shall be provided to the departments and units according to the communication needs. Such telephones shall be used for official calls only.

ii. Access to Internet and e-mail facilities shall be provided to all staff based on their job scope.

iii. The mobile phones can be used to facilitate communication between the hospital staff especially in times of emergency.

iv. Intercom facilities shall be used in some department where hands-free communication is required.

v. A two-way communication system shall be provided in the ambulances for communication between the ambulance and the base in the emergency department.

vi. Fax facilities shall be provided in certain places to be shared between departments and units. Fax shall be used only when there is an urgency to send a letter or document.

vii. Use of hand phone shall not be allowed in the wards especially in critical care areas.

13.2 Patient/Public communication

i. A call centre located in the emergency department shall be used to receive emergency calls from the public.

ii. Department and units in the hospital shall be contactable by the public using the general telephone lines.

iii. A nurse call system in the ward shall be used by patients to alert the nurse whenever there is a need or during emergency.

iv. The public address (PA) system shall be used for making announcements, provides information and education as well as entertainment in the form of light music. For emergency call or announcements, specific codes shall be used.

v. Digital Call System shall be used at the registration counter, clinic and at the pharmacy counter.

vi. Public telephone shall be used by all for personal/private communication.
14 TRANSPORT

14.1 Vehicles

i. The ambulances shall be under the responsibility of the Assistant Medical Officer’s Unit. Other vehicles shall be managed by the Administration Unit.

ii. Hospital vehicles shall be used for specified purpose as follows,

- The ambulances for pre-hospital care and for inter-hospital transportation of patients.

- The hearse (for Muslim and for non-Muslim) shall be used to transport back the bodies of deceased patients referred from other government hospital.

- The vans/MPV shall be used to transport supplies and materials.

- The saloon cars shall be used to transport staff.

iii. Hospital vehicles shall be driven by hospital drivers with valid driving license.

iv. Approval from authorized personnel shall be obtained for the use of any hospital vehicles.

14.2 Porter service

i. A senior assistant medical officer shall be appointed to manage and coordinate the central porter service.

ii. The central porter service shall be available from 8.00am to 5.00pm. After office hours / public holiday porter service is provided by on call basis.

iii. The central porters shall be responsible for the transfer of patients between Emergency and wards.

iv. The central porters shall be responsible to accompany patient on transfer to another hospital.
15  HOSPITAL SECURITY

15.1 General

i. The different areas in the hospital shall be identified either as high, medium or low security. Examples of high and medium security areas are the entrances, stores, revenue unit, wards and delivery suites.

ii. Areas identified as high security shall have security measures installed and security guards placed full time. Other areas shall have a regular site patrol by the security guards.

iii. Clear ‘no entry’ signs shall be placed in areas and on doors to the rooms, which are restricted for staff or authorized personnel only.

iv. Patients shall be responsible for their own belongings. For unconscious patient, the relevant department/unit shall be responsible for the safe keeping of patient’s property.

v. The department and unit heads shall be responsible for the security procedures within the department and staff compliance to the procedures

15.2 Visiting hours

i. The visiting hours shall be as follows,

   **Weekdays and Saturday**
   
   12.30 pm - 2.00 pm  
   4.30 pm - 7.30 pm

   **Friday**
   
   12.00 pm - 2.00 pm  
   4.30 pm - 7.30 pm

ii. During visiting hours, relatives shall be allowed to visit patients in the general wards.

iii. Visit to the critical care areas shall be restricted to two per patient at any time.

iv. Children aged below 12 shall not be allowed to visit patients in the wards.

15.3 Non-visiting hours

i. Number of visitors shall be restricted after visiting hours. A visit pass (pas pelawat) shall be provided at security checkpoint and only 2 visitors per patient are allowed at a time. After 9.00 p.m. a visit shall not exceed more than 15 minutes.
ii. All visits after visiting hours shall be recorded. Visitors may be required to leave identification document in exchange for the pass. Such document shall be returned at the end of the visit.

iii. A relative shall be allowed to accompany patient subject to the approval of the ward staff. A special pass (pas menunggu) shall be issued to one person for the following situation,

- Relatives to accompany critically ill and bed ridden patients. Only female relative shall be allowed to accompany patient in the female ward/cubicle.
- Mothers or guardians to accompany children in the pediatric wards.
- Mothers of babies admitted to the special care nursery for breastfeeding.

15.4 Hospital Visitors

i. Registered hospital volunteers and members of the Board of Visitors with identification cards shall be allowed to enter the hospital during office hours and at daytime during public holidays.

ii. VIPs on official visit shall be escorted by the hospital staff.

iii. Other visitors shall be required to use a visit pass.

15.5 Traffic Control

i. The hospital shall implement a proper traffic system within the hospital to avoid traffic congestion.

ii. In case of fire in the hospital, the Bomba shall be allowed to enter the hospital from any gates, preferably the nearest to the fire location.

iii. Drop-off and pick-up zone shall be provided near the entrance to specialist clinic for patients’ convenience.

iv. Parking outside the parking areas shall be prohibited. The hospital shall not be responsible for any summons issued/ clamping or towing done on the vehicle due to wrong parking.

v. The hospital shall not be responsible for the safety of the vehicles.

16 PATIENT & STAFF SAFETY

16.1 General

i. Prisoners and detainees shall be placed in single rooms when available. The police or prison personnel shall accompany such patients at all times.

ii. Depressed patient or patient with high suicidal tendency shall be closely monitored. Such patient shall not be left on their own.
iii. Children shall not be allowed to go out from the ward unaccompanied.
iv. Newborn babies shall not be taken out from the ward without prior permission from the mother.

16.2 Fire safety
i. The Hospital shall appoint a fire safety Officer and have its own fire contingency plan.
ii. Appropriate fire equipment shall be made available in all areas and regularly maintained.
iii. The person in charge of the respective areas shall ensure regular inspections are carried out on all the fire fighting facilities, fire-retardant doors and escape routes. He or she shall also be responsible for the fire safety procedures and ensure the staff adheres to these procedures.
iv. Fire retardant doors shall be kept closed at all times but not locked. If exit doors need to be locked (for patient safety), the keys shall be made readily available.
v. In the event of fire, patients shall be evacuated in accordance to the principle of horizontal evacuation and if the fire continues to spread, to move vertically down.
vi. Staff shall receive training on fire safety, evacuation procedures and use of fire fighting equipment. Fire drill shall be conducted regularly, at least once a year.

16.3 Infection control
i. Hospital Infection Control Committee shall be established to monitor and coordinate all activities related to infection control. Issues pertaining to hospital infection shall be presented to the Committee for acknowledgement and further action.
ii. An infection control coordinator shall be appointed. The coordinator together with the liaison officer (link nurse/staff) from each area/ward shall form the infection control team.
iii. The team shall monitor the implementation of infection control procedures, carry out surveillance activities, and monitor antibiotic pattern and conduct training of hospital staff.
iv. Infectious patients shall be placed and nursed in single rooms wherever possible. The use of multi – bedded rooms for the same type of infection is acceptable.
v. Medical personnel shall wash their hands before and after examining patient at the wash–hand basins with elbow taps in all wards and patient-care areas.
vi. All staff has to comply with 5 moments hand hygiene and 7 steps of hand wash.
vii. Staff shall be instructed to adhere to the standard precaution guidelines all the time. This includes frequent hand washing and the use of gowns by those having direct contact with an infectious patient.

viii. All instruments and linen used by infectious patients shall be placed in special bags (without washing or soaking)

ix. All clinical waste from infectious patients shall be double–bagged in yellow plastic bags for disposal by incineration. Management of the clinical waste shall be as in the privatisation contract.

16.4 Radiation protection

i. The hospital shall establish a Radiation Protection Committee and appoint a Radiation Protection Officer to oversee and coordinate activities related to radiation protection.

ii. Request for radiological imaging shall be done by a medical practitioner in writing using the standard form. The requesting doctor shall be responsible to screen patient for risk factors prior to the examination.

iii. Facilities or rooms where x-ray examinations are carried out shall have the necessary safety features such as lead lined screen, walls or doors.

iv. Policies and procedures pertaining to radiation safety and protection shall be made available to all the relevant department and units.

v. Staff in the radiological department and in other department where ionizing radiation machines are used shall be briefed on the policies and procedures on radiation safety and protection.

vi. Staff shall adhere to the regulation and guideline regarding the use, storage and disposal of ionizing radiation and the guideline on diagnostic imaging for pregnant women and women of childbearing age.

vii. Only qualified and trained personnel shall be allowed to operate the x-ray equipment. The radiographer and the assisting person involved shall wear the necessary attire for protection such as lead gown, thyroid shield etc.

viii. Staff working in x-ray controlled areas shall have radiation dose monitoring done. Outside the main imaging department, the radiation dose monitoring shall be carried out using pen dosimeter.

ix. Staff exposed to radiation shall have their blood count checked regularly and undergo necessary medical examination.
17 GENERAL AMENITIES

17.1 Car park

i. Car park shall be designated for staff and public. Only cars with hospital stickers shall be allowed to enter the staff parking area. A few parking lots shall be allocated for disabled patients.

ii. Notices shall be put up to inform the public that they park at their own risk. The Hospital shall not be responsible for the safety of the vehicles.

17.2 Staff facilities

i. Staff facilities shall either be allocated to individuals (examples are office room and rooms in nurse hostel) or commonly shared by all staff (examples are the rest room and staff change).

ii. The common user areas shall be either under the responsibility of the General Administration or the specific department where it is located.

iii. Staff on call shall be provided with a room within the department or unit. The on-call room in the ward shall be used by the doctor on-call.

iv. Accommodations or quarters shall be provided to some staff. Allocation of quarters shall be carried out by the Housing Committee based on eligibility. Priority shall be given to those working in critical areas and required to be on stand-by in case of an emergency.

17.3 Public facilities

i. Public facilities shall be under the responsibility of the General Administration Unit. The following are some of the facilities available for public use,
   - Visitor’s lounge
   - Prayer rooms
   - Cafeteria
   - Wash room and toilet
   - Shops /kiosk

ii. Visitor’s lounge shall be opened 24 hours as a rest place for patient’s relatives. Those who use the lounge shall be subjected to the rules and regulation of the hospital.

iii. Prayer rooms shall be opened for 24 hours to the public and staff.

iv. The hospital cafeteria shall be opened to the public and staff. Pre-prepared food shall be sold in the cafeteria.
18 PUBLIC RELATIONS

18.1 Information counter

i. An information counter shall be made available to provide information and directions to patient and public.

ii. Appropriately trained and suitable staff shall be placed at the counter.

18.2 Complaints

i. Suggestion boxes shall be placed at strategic locations to get feedback and comments from the public. The suggestion box shall be inspected weekly.

ii. The General Administration Unit shall be responsible for monitoring comments or complaints received through the suggestion box and complaints in the newspaper.

iii. Complaints in the newspapers shall be notified to the director and the relevant department/unit early in the morning before 9.00 am.

iv. All complaints received shall be documented and key into the system i-SPAAA (Sistem Pemantauan Aduan Agensi Awam Bersepadu). The complaints shall be investigated and appropriate action taken.

v. Acknowledgement letter shall be issued within 1 working day of receiving the complaint.

vi. Investigation report shall be submitted to the relevant authority within 2 weeks of receiving the complaint.

18.3 Release of information

i. The hospital shall not make any statement on policy matters and on issues of public concern, to the public or media without prior approval from the Ministry.

ii. Patient information shall not be released without prior approval from the patient.

18.4 Photography/films/interviews

i. The media shall be allowed to interview or take the patient’s photograph only on approval of the hospital director and consent of the patient or the relative.

ii. Generally film or drama shooting shall not be allowed in the hospital compound. If permission is given by the Ministry or State, it shall be subjected to the hospital’s rules and regulation and at the convenience of the hospital.

iii. Use of hospital ambulances or equipment shall not be allowed.
18.5 Public function/exhibition

i. Hospital shall organize talks or exhibition to provide health education to the public.

ii. Health activities shall also be organized to create public awareness and encourage public participation.

19 GENERAL ADMINISTRATION

19.1 Letters and document

i. The General Administration Unit shall be responsible for the management of all incoming and outgoing official letters. The unit is also responsible for the management of hospital file and the filing system.

ii. Incoming letters shall be dispatched to the respective department/unit on the same day or the next morning. Letters shall be dispatched using pneumatic tube. For urgent letters, the respective department/unit shall be informed by telephone.

iii. All outgoing official letters shall use the standard letterhead of the hospital. Official letters shall be written according to the standard format and signed by the director or on approval of the director. All incoming and outgoing letters shall be filed in the main hospital file.

iv. Documents classified under the Official Secret Act shall be opened by authorized personnel and handed personally to the officer concerned. Such letter or documents shall be filed separately.

v. Files shall be kept for the required number of years. Disposal of files and documents shall be in accordance to the procedures and guideline issued by Arkib Negara.

19.2 Office equipment and supplies

i. The General Administration Unit shall coordinate the requirement and manage the non-medical supplies and office equipment excluding IT equipment.

ii. The department and unit head shall be responsible for maintaining the inventory list and ensure proper use of office supplies and equipment.

iii. Certain office equipment shall be shared among several department and unit. Shared equipment shall be under the responsibility of the department/unit where the equipment is located.

19.3 Meetings

i. Meeting rooms in the main office shall be used for the hospital committees meetings and meetings involving several department and units. The General Administration Unit shall coordinate the use of meeting rooms in the main office.
ii. Meetings shall be well organized and documented. Call letters shall be sent out before the meeting and the minutes circulated within a week after the meeting (working days). A copy of the minutes shall be kept in the relevant file.

20 HUMAN RESOURCE

20.1 Orientation

i. Staff newly appointed shall be informed about the terms and conditions of appointment as in the General Order and PKPA. The staff also has to sign some document such as “Aku Janji”, “Akta Rahsia Rasm 1972”.

ii. All staff shall be given an overall briefing on the hospital policies, procedures, rules and regulation and their roles and responsibilities.

iii. Specific briefing shall be given by the departments and units.

20.2 Placement

i. Placement of staff to departments or units shall be based on qualification, specialized training received, years of experiences and service needs.

ii. The head shall be responsible for the placement and job description within the department/unit.

iii. Deployment and rotation of staff to other department and unit shall be carried out when necessary.

20.3 Work attendance

i. Staff shall record their daily attendance and movement in the punch card once a month and inform to Administration unit.

ii. Department /unit head shall be responsible for monitoring their staff daily attendance/movement.

iii. Staff shall submit leave form well in advance before taking leave. They shall make sure the leave has been approved before taking the leave.

iv. Staff shall inform their department/unit head if they are not well and has been given medical certificates.

20.4 Dress code & work behavior

i. Staff shall wear their respective uniform or proper working attire in accordance to the hospital guideline.
ii. Name tags shall be worn all the time as part of the uniform/working attire.

iii. During working hours, staff shall behave well and carry out their duties professionally so as to uphold the image of the hospital.

iv. Staff with disciplinary problems shall be given counseling before being referred for disciplinary action.

20.5 Performance evaluation

i. Staff shall be provided with a ‘fail meja’ which contain his/her job description, responsibility and accountability and work process.

ii. Performance evaluation shall be carried out annually using Human Resource Management Information System (HRMIS). Staff who perform very well shall be recommended for the excellent service award (anugerah khidmat cemerlang)

iii. Department/unit shall have its own system to evaluate technical competencies.

20.6 Staff Welfare

i. The hospital shall establish Kelab Sukan dan Kebajikan, Badan Kebajikan etc. to provide opportunity for the staff to get together, participate in sports or carry out other recreational activities.

ii. Hospital shall establish wellness clinic for the staff.

iii. Majlis Bersama Jabatan shall be established to discuss matters relating to services and personnel.

20.7 Professional development

i. Staff shall be responsible for their own professional development to improve work performance.

ii. Staff shall be required to attend CME session for at least 10 hours in a year.

iii. Staff shall be given opportunity to attend CME either through hospital sponsorship or unrecorded leave.

21 FINANCE

21.1 Allocation and expenditure

i. Hospital fund shall be allocated according to Activity and sub-Activity.

ii. The head of the Activity shall be responsible for putting up justifications for additional budget.
iii. A Finance Committee shall be established to discuss financial and account issues including expenditure status, budget reallocation and additional requirement every three months

21.2 Procurement

i. Procurement of items shall be carried as follows,
   • Above RM500,000 - tender
   • Between RM50,000 – RM500,000 - “sebut harga”
   • Below RM50,000 - direct offer

ii. Procurement shall be carried out in accordance to the government financial procedure.

iii. Local order shall be issued only by authorized personnel.

21.3 Claims and loans

i. Staff shall be required to submit claims within 10 days of the following month. Claim forms shall be completed, signed and attached with the necessary forms and receipts.

ii. Head of department/unit shall be responsible for checking and verifying the claims before submitting to the Finance Unit.

iii. Government loan application shall be submitted based on eligibility and attached with the necessary forms and document.

iv. Salary deduction shall be carried out on written instruction from the staff or from the central agency for payment of loan/income tax.

22 HOSPITAL REVENUE

22.1 Hospital fees

i. Fees shall be charged in accordance to the Fees Act and the MOH Finance Division circular.

ii. Patient going for admission without having guarantee letter shall be required to pay a deposit.

iii. Additional deposit shall be collected from patient when the estimates of hospital bill exceed the payment of deposit.

iv. Exemption shall be given to certain group of patients as approved by the Treasury.
v. Exemption to individual patients shall only be given when there is a supporting letter from an authorized person as stated in Ministry’s circular.

22.2 Billing & payment

i. The hospital bill shall be given on discharge and patients are required to settle the bill at the revenue counter before going home.

ii. The hospital shall receive payment in cash or using credit card. Personal cheque shall not be accepted.

iii. Receipts shall be issued upon payment.

iv. For patients who produce valid guarantee letter on admission, the bill shall be sent to the employer.

23 TRAINING & RESEARCH

23.1 Structured course

i. Staff shall be informed through the department or unit head regarding courses or training program run by the Ministry of Health or outside agencies.

ii. Staff applying for such courses shall have to fulfill the criteria specified in the training programme.

iii. Applications shall be submitted to the Human Resource Unit before the closing date. Submission shall be made through the department or unit.

23.2 Continuing professional development

i. Each hospital shall establish a structural organization to provide the direction and governance for the CPD programme.

ii. To maintain staff competency, which include technical, soft skill and communication skill, each personnel (both administrative and clinical) will be given the opportunity to attend training programmes in areas relevant to their functions, of not less than 7 days.

iii. Sufficient funding and other resources which may include library, auditorium, seminar room, skill lab, computer lab, etc. will be established in each hospital.

iv. Each hospital is encouraged to establish formal and informal linkages and collaborations with local and international health-related organizations to facilitate training activities.

v. Database of in-house and external training programmes organized and/or attended by each personnel must be maintained and updated.

vii. CME activities shall be carried out both at hospital and departmental level. Hospital CME shall be organized at least once a week.

viii. Staff shall be given opportunities to attend relevant seminars or courses outside the hospital.

ix. The staff shall have access to the hospital library and to on-line educational web page through the internet.

23.3 Credentialing & Privileging

i. Each hospital shall establish a structural organization and mechanism for purposes of credentialing and/or privileging of clinical personnel relevant to type of services being offered. (Refer to Guidelines: Sistem Credentialing dan Privileging di Kementerian Kesihatan Malaysia Bil 01/2001).

ii. All visiting specialists required to obtain credentialing & privileging certificate from the hospital credentialing & privileging committee.

iii. All non-government medical practitioners practicing in a government facility as university lecturers, locum, training attachments or on sessional basis shall be required to obtain a written approval to practice in a government facility, from the Director-General of Health in accordance to Section 34C of the Medical Act 1971.


23.4 House Officers and other Post-basic/Graduate training/Master program and Subspecialty Training

i. A hospital that has been designated as a training center for undergraduates / House Officers and/or other post- basic /graduate programme is required to establish a formalized training and assessment structure relevant to the type of training being provided (refer to Buku Panduan Program Pegawai Perubatan SiswaEdisi 2012)

23.5 Research

i. Staff shall be allowed to carry out or participate in research organized by the Ministry, university or other government agencies.

ii. Research proposal in clinical areas, shall require approval of the National Ethic Committee in the Ministry of Health.
iii. Research carried out in the hospital shall have to comply with the rules and regulations. Patient’s identity shall be kept confidential.

24 QUALITY MANAGEMENT

24.1 Standard & indicators

i. The national indicators shall be used to monitor the hospital achievement.

ii. All non-conformers shall be investigated to find out the cause and to carry out remedial action.

24.2 Quality improvement activities

i. The department and unit shall be responsible for the provision of quality service.

ii. The department and unit shall establish their own standards and indicators for monitoring quality.

iii. The department and unit shall carry out and document all the quality improvement activities.

iv. The hospital shall establish a Quality Management Committee to oversee and coordinate all activities on quality. Separate coordinators shall be appointed for the different activities.

v. The following quality activities shall be implemented,

- Quality assurance
- Incident reporting
- Patient satisfaction survey
- Hospital Accreditation, and
- Other Quality Improvement Activities

25 HOSPITAL SUPPORT SERVICES

25.1 General

i. The following 6 support services shall be privatized in accordance to the specifications in the contract prepared by the Ministry.

- Cleansing Services (CLS)
- Linen and Laundry Services (LLS)
- Hospital Waste Management System (HWMS)
- Biomedical Engineering Maintenance Service (BEMS)
- Facility engineering Maintenance Service (FEMS)
- Facilities Management Services (FMS)
ii. The administration unit shall be responsible for the overall coordination of the 6 services. A Liaison Officer for each service shall be appointed to monitor and coordinate all the activities and to ensure compliance to the Technical Requirement and Performance Indicators (TRPI), the Master Agreed Procedures (MAP), Project Operation Guidelines (POG) and the Hospital Specific Implementation Plan (HSIP).

iii. The overall coordinator shall have regular monthly meetings with the liaison officers regarding issues and remedial action to be taken to improve the services.

iv. There shall be a committee to decide on deductions for non-complied services.

25.2 Cleansing Services

i. Roster /schedule agreed by staff
ii. Usage of color coded mops and technique of mopping
iii. Appropriate usage of detergents.
iv. Training on cleansing.
v. Scheduled Joint inspection

25.3 Linen & Laundry Services

i. All linen shall be delivered in a manner, which provides full protection from contamination during handling and transportation.

ii. Clean linen already checked and folded to an agreed pattern shall be supplied according to schedule.

iii. Supply of clean linen shall be on a top-up basis and comply with par level of each ward/ unit/ department/ OT as agreed in the HSIP.

iv. Linen shall be transported in designated clean or soiled linen carts.

v. Linen supplied to the ward and kept in the linen store or cupboard shall be under the responsibility of the ward staff.

vi. Used bed linen shall be changed every other day or when necessary.

vii. Patient’s hospital clothing shall be changed daily and when necessary.

viii. All other linen such as curtain, cushion covers and screen curtains shall be changed according to agreed schedule and when necessary.

ix. Soiled linen from wards, OT and other departments shall be placed in color-coded bags (Red - infected, Green - OT linen and White - soiled) provided by the concessionaire and collected at the respective areas by the concessionaire as per agreed schedule.
25.4 Hospital Waste Management System (HWMS)

i. Waste shall be handled in accordance with standard precaution and infection control measures.

ii. The transportation of clinical and general waste shall follow a designated route as agreed by Hospital Privatization Committee.

iii. The chemical waste shall be handled appropriately in accordance to the requirement of “Environmental Act 1974’ and Environmental Quality (Scheduled Waste) Regulations 1989.

iv. Processing Chemical waste from the Diagnostic and Imaging department and the waste from hemodialysis unit shall be disposed through sewage system.

v. Chemical waste from the pathological department shall be collected in containers and disposed accordingly to the guidelines. Storage of chemical wastes prior to its disposal shall be at an isolated area.

vi. The Concession Company shall handle the disposal of expired drugs.

vii. “Guidelines on the Disposal of Chemical Wastes from Laboratories, 2000 by Department of Environment, Ministry of Science, and Technology & Environment, Malaysia” shall be referred to for detailed procedures in handling of chemical waste

25.5 Facility & Biomedical Engineering Maintenance System

i. The concession company shall be responsible for carrying out planned preventive maintenance according to the schedule recommended by the manufacturers of equipment.

ii. The regular maintenance service of mechanical, electrical, civil and bio-medical equipment within the warranty period shall be undertaken by the vendors through Hospital Support Service.

iii. The Hospital Support Service shall rectify any breakdown within the shortest possible time as specified in the TRPI.

iv. Any improvement/alteration work and reimbursable work required shall be referred to the Hospital Director for approval.

25.6 Facilities Management Services (FMS)

i. Facilities Management Services (FMS) is aimed to ensure the services and other obligations are smoothly managed, planned and delivered in accordance to the Government’s requirements under the Concession Agreement (CA), with a focus on patient safety and quality of the Hospital Support Services (HSS) deliveries.
i. FMS provided by the company shall be of satisfactory level, and will abide by the Technical Requirements and Key Performance Indicators (TRKPI) and Master Agreed Procedures (MAP).

ii. Scope of FMS includes provision of comprehensive management and coordination of the other five HSS services, including manpower, training, outsourced services, performance review of HSS, consultation, management of facilities and documentations, quality and improvement for efficient and effective service deliveries.

26 DISASTER MANAGEMENT

26.1 Disasters Plan

i. There shall be an Emergency Management Committee headed by the Hospital Director. The members of the committee shall include the clinicians, representatives from the relevant department/unit and representative from the privatized support services.

ii. The committee shall be responsible for the preparation of the Disaster Management Plan, Hospital Contingency Plan and its implementation. Meetings shall be held regularly to discuss issues and remedial measures.

iii. In the event of disaster, the Hospital Director shall declare red alert and activate the disaster management plan.

iv. The Disaster Management Plan shall include the followings,

- The emergency alert system
- List of posts and responsibilities
- Medical teams
- Management of the victims
- Documentation and statistics

v. All staff shall be briefed on the Disaster Management Plan and their roles and responsibilities. Appropriate training shall be carried out.

vi. A disaster drill shall be organized regularly at least once a year.

vii. Department and unit head shall be responsible for the disaster plan of their own department/unit.

26.2 Hospital evacuation

i. The hospital shall have a plan for evacuation of building.

ii. Staff shall be briefed on the evacuation plan, exit routes and the gathering site.
iii. An exit route plan shall be displayed at strategic location in every department/unit/ward.

iv. An evacuation drill shall be carried out at least once a year.

26.3 Specific contingency plan

i. A specific contingency plan shall be made available for the following situation,

- Power failure
- IT system breakdown
- Lift breakdown
- PABX breakdown
- Cut in water supply
- Gas leakage
- Flood
- Disease outbreak
- Air condition failure
- Building infestation
- Bomb threat “Ancaman Bom”

ii. The plan shall include notifications, allocation of responsibilities, immediate actions and alternative solutions with follow up measures.