SERVICE STANDARD 09H : CLINICAL SERVICES - OTORHINOLARYNGOLOGY

PREAMBLE

Otorhinolaryngology Services play an integral role in delivering appropriate care and reducing unwarranted adverse events, as they meet the care people expect to be offered or receive, regardless of where they are treated in the Facility.
The Othorinolaryngology Service shall be organised, directed and coordinated with other services in the Facility in particular of audiology and speech therapy services to provide a high standard of inpatient and outpatient care to the community and cover the following:
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 Otorinolaryngology Service also conduct teaching and training, research and audit activities where applicable.

TOPIC TOPIC 9H.1
ORGANISATION AND MANAGEMENT

STANDARD STANDARD 9H.1.1

The Otorhinolaryngology Service shall be organised, directed and coordinated with other services as above in the Facility to provide a high standard of inpatient and outpatient care to the community in a safe, efficient, effective, evidence based and caring manner and with due regard for the needs, dignity and privacy of patients and confidentiality of their personal information. The Otorhinolaryngology Service shall be easily accessible and continuity of care assured.

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
9H.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Otorhinolaryngology Service are clearly documented and measurable that indicates safety, quality and patient centred care. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.	NA			NA	
	EVIDENCE OF COMPLIANCE					
	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body. — NA					

	2.	Goals and objectives of the Otorhinolaryngology Services in line with the Facility statements are available, endorsed and dated.	NA				
	3.	Evidence of planned reviews of the above statements.	NA				
	4.	These statements are communicated to all staff (orientation programme, minutes of meeting, etc)	NA				
	5.	Achievement of goals and objectives are monitored, reviewed and revised accordingly.	NA				
9H.1.1.2 CORE	There is an organisation chart which: a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head of Otorhinolaryngology Service, consultants, medical practitioners and staff of the Otorhinolaryngology Service; b) reflect the relevant subspecialties services/units and allied health services (Audiology and Speech Therapy); c) is accessible to all staff and clients; d) is revised when there is a major change in any of the following: i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head of Otorhinolaryngology Service, relevant subspecialties services/units, consultants, medical practitioners , allied health services (Audiology and Speech Therapy); and staff of the Otorhinolaryngology Services.	NA				
	2.	Organisation chart of the service is endorsed, dated and accessible.	NA				
	3.	The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv).	NA				
9H.1.1.3	The Governing Body shall ensure that Otorhinolaryngology Service are organised in such a way as to: a) facilitate the provision of Otorhinolaryngology service to patients in the Facility in a safe, efficient, effective, and caring manner and with due regard for the needs, dignity and privacy of patients and confidentiality of their personal information; b) assure continuity of care;		NA			NA	

	c) address the professional needs of the medical practitioners; d) ensure that the medical practitioners are involved in the formulation of policies and procedures concerning patient care appropriate to the scope of services of the Facility. **EVIDENCE OF COMPLIANCE** 1. Departmental/Service operational policies that address (a) to (d). NA 2. Medical Staff By-Laws NA 3. Evidence of involvement of medical practitioners in the formulation of policies and procedures concerning patient care. NA 4. Involvement of Head of the Service in the Medical and Dental Advisory Committee/Medical Advisory Committee and ward meetings. NA 5. Minutes of meetings NA 6. Proper and adequate facilities and equipment according to current standards. NA					
9H.1.1.4	There is a mechanism to ensure effective interaction between the Otorhinolaryngology Service and the Governing Body on all clinical aspects of healthcare and other relevant matters in the Facility. This mechanism is defined in the policies of the Governing Body and is accomplished through: a) the appointment of a medical practitioner as the Head of Otorhinolaryngology Service delineating his/her authority, responsibilities and accountabilities in a written document according to the relevant Acts to manage and control the Otorhinolaryngology Service; b) Medical and Dental Advisory Committee (MDAC) to advise the Governing Body on issues related to clinical governance, i.e. in planning, coordinating, implementation, control and to improve activities relating to Otorhinolaryngology Service. **EVIDENCE OF COMPLIANCE** 1. Letter of appointment/assignment and delineation of duties and responsibilities of the Head of the Service. NA	NA			NA	

	2.	Letter of appointment and Terms of Reference as member of the Medical and Dental Advisory Committee/Medical Advisory Committee.	NA				
	3.	Minutes of meetings of MDAC/Management	NA				
9H.1.1.5 CORE	The Head of Otorhinolaryngology Service has: a) representation of the Service in committees and subcommittees where relevant; b) representation of the Service in clinical staff liaison meetings; c) involvement and provide regular input to the Senior Management Team.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Letter of representation of the Head of Service in committees and subcommittees where relevant, e.g.Blood Transfusion Committee, Medical Records Committee, Hospital Infection and Antibiotic Control Committee, Credentialing and privileging Committee, Operating Theatre committee etc.	NA				
	2.	Minutes of meetings of committees	NA				
	3.	Minutes of meeting of Senior Management Team.	NA				
9H.1.1.6	The assessment, planning, direction, evaluation and continuity of clinical care are the responsibility of medical practitioners managing individual patients, thus ensuring clinical independence.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Medical Staff By-Laws; clause indicate clinical care responsibility of medical practitioners.	NA				
	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.	NA				
9H.1.1.7	The Head of Otorhinolaryngology Service shall be involved for the following aspects of management of the services: a) the preparation of budget and ensuring that expenditure remains within the budget allocated; b) human resource management and development;			NA			NA	

	c) development of policies and procedures and ensuring compliance to them; d) facility and equipment management; e) safety and performance improvement activities and risk management. **EVIDENCE OF COMPLIANCE** 1. Evidence of (a) to (e) in the minutes of meetings of Otorhinolaryngology Service indicate the involvement of Head of Service. — NA 2. Endorsement of policies and procedures — NA 3. Request for allocation of budget and staffing — NA 4. Implementation of performance improvement activities — NA					
9H.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 Otorhinolaryngology Service. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented. **EVIDENCE OF COMPLIANCE** 1. Minutes are accessible, disseminated and acknowledged by the staff. — NA 2. Attendance list of members with adequate representatives of the service. — NA 3. Frequency of meetings as scheduled. — NA 4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved). — NA	NA			NA	
9H.1.1.9	Where there are medical practitioners in training, there is evidence that: a) their responsibilities for patient care are documented; b) their training needs are identified; c) appropriate supervision and training are given to the medical practitioners concerned. **EVIDENCE OF COMPLIANCE** 1. Structured training programmes for medical practitioners are in place. — NA 2. Training timetable, continuing medical education and attendances list — NA 3. Assessment reports — NA	NA			NA	

	4.	Log books	NA				
9H.1.1.10	Appropriate statistics and records shall be maintained in relation to the provision of Otorhinolaryngology Service and used for managing the services and patient care purposes.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Records are available but not limited to the following:						
	a)	workload/census for inpatients and outpatients;	NA					
	b)	annual report;	NA					
	c)	accident/incident reports;	NA					
	d)	staffing number and staff profile;	NA					
	e)	staff training and competency records;	NA					
	f)	data on performance improvement activities, including performance indicators.	NA					

TOPIC TOPIC 9H.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD STANDARD 9H.2.1
CREDENTIALING AND PRIVILEGING
The Otorhinolaryngology Service shall be directed by a qualified and competent medical practitioner, and staffed by suitably qualified and competent clinical staff to achieve the goals and objectives of the Otorhinolaryngology Service.

<table>
<tr><th rowspan="2">CRITERION NO.</th><th rowspan="2">CRITERIA FOR COMPLIANCE</th><th rowspan="2">SELF RATING</th><th rowspan="2">FACILITY COMMENTS</th><th colspan="3">SURVEYOR FINDINGS</th></tr>
<tr><th>AREAS FOR IMPROVEMENT / RECOMMENDATIONS</th><th>SURVEYOR RATING</th><th>RISK</th></tr>
<tr><td>9H.2.1.1
CORE</td><td>There is documented evidence of appropriate training and competency for the granting of clinical privileging. The criteria for determining privileges are specified and documented. There is a structured process to ensure the stated criteria are uniformly applied to all applicants. These include:
a) the criteria are designed to assure that patients will receive safe and quality care;
b) the criteria for individual procedures are documented in detail; e.g. competency records/log books, application from the individual practitioner, recommendations from peer/referee and minutes of meeting;
c) competency for each performance is dated, verified and signed by the supervisors;
d) the period of time for which the privileges are to be granted is specified;
e) current registration with the local professional registration bodies, e.g. Malaysian Medical Council, National Specialist Register (NSR);
f) peer recommendations are taken into account when privileges are being considered;
g) the recommendations of the relevant department and/or major professional services for privileges to be granted are taken into consideration.

EVIDENCE OF COMPLIANCE
1. Documented policies and procedures are established to govern the credentialing and privileging processes which include items (a) to (g). — NA
2. Compliance with policy and criteria for credentialing and privileging — NA
3. Annual Practising Certificate (APC), National Specialist Register (NSR) certificate and privileging certificate. — NA
4. Recommendations from peer/referee — NA
5. Availability of the list of procedures requiring credentialing and privileging. — NA</td><td>NA</td><td></td><td></td><td>NA</td><td></td></tr>
</table>

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

	1.	Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e).	NA				
	2.	Job description includes specialisation skills	NA				
	3.	Relevant privileges granted where applicable	NA				
	4.	The job description is acknowledged by the staff and signed by the Head of Service and dated.	NA				

STANDARD STANDARD 9H.2.2

STAFF TRAINING, EDUCATION, APPRAISAL AND RESEARCH

The Facility and all staff shall demonstrate an ongoing commitment to continuing medical education.

CRITERION NO.	CRITERIA FOR COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
9H.2.2.1	There are continuing education activities for staff including medical practitioners to pursue professional interests and to prepare for current and future changes in practice.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Training calendar includes in-house/external courses/ workshop/conferences	NA				
	2.	Contents of training programme	NA				
	3.	Training records on continuing education activities are kept and maintained for each staff including training in life support.	NA				
	4.	Certificate of attendance/degree/post basic training	NA				
9H.2.2.2	The educational needs of staff and the Facility, as evidenced by the results of medicalcare evaluation such as incident reports, performance improvement studies and complaints, are taken into consideration when the content and structure of educational activities are planned.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Evidence of inclusion of results of audit activities, e.g. mortality and morbidity reviews, incident reporting, etc in educational activities.	NA				
	2.	Evidence of improvement made from corrective or preventive measures from incident reports.	NA				
9H.2.2.3	In a Facility where undergraduate medical, nursing and allied health training programmes are conducted, the Facility shall ensure that there are sufficient skilled trained staff to provide clinical supervision of students.		NA			NA	
	EVIDENCE OF COMPLIANCE						

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

STANDARD STANDARD 9H.2.3

STAFFING LEVEL AND STAFF COMPETENCY

The Head and staff of the Otorhinolaryngology Service including medical practitioners are individuals qualified by education, training and experience commensurate with the requirements of the various positions and relevant laws.

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
9H.2.3.1	Deployment of all service providers for Otorhinolaryngology Service takes the following factors into consideration: a) the number of persons deployed is proportional to the number of patients being cared for as in the regulatory requirements and for the intensity of care provided; b) the categories of service providers based on qualifications and experience providing care reflect the complexity of clinical problems being managed; c) staffing needs shall take into consideration absences due to leave or illness; double shift duties by clinical staff shall be documented and monitored; d) adequate staffing levels of appropriate competency shall be maintained throughout the hours the services are in operation. Where services need to be provided on a 24-hour basis, staffing level reflects the intensity of activities during each shift; e) where it is not possible to have service providers on duty on site, e.g. after working hours, provision is made for relevant medical practitioner to be available on call.	NA			NA	

EVIDENCE OF COMPLIANCE		
1.	Documentation and planning on deployment of staff that includes but not limited to (a) to (e) with evidence of:	
a)	deployment based on staff to patient ratio, bed occupancy rate and complexity of cases;	NA
b)	special skills/training of staff;	NA
c)	contingency plan during acute shortage	NA
d)	duty roster	NA

STANDARD STANDARD 9H.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.

<table>
<tr><th rowspan="2">CRITERION NO.</th><th rowspan="2">CRITERIA FOR COMPLIANCE</th><th rowspan="2">SELF RATING</th><th rowspan="2">FACILITY COMMENTS</th><th colspan="3">SURVEYOR FINDINGS</th></tr>
<tr><th>AREAS FOR IMPROVEMENT / RECOMMENDATIONS</th><th>SURVEYOR RATING</th><th>RISK</th></tr>
<tr><td>9H.2.4.1</td><td>There is a structured orientation programme for all newly appointed staff to the Otorhinolaryngology Service including medical practitioners and for those new to specific areas that include the following:
a) explanation of the goals, objectives, policies and procedures of the Facility and those of the Otorhinolaryngology Service;
b) lines of authority and areas of responsibility;
c) explanation of particular duties and functions;
d) explanation of the methods of assigning clinical care and the standards of clinical practice;
e) handover communication;
f) processes for resolving practice dilemmas;
g) information about safety procedures;
h) training in basic/advanced life support techniques;
i) methods of obtaining appropriate resource materials;
j) staff appraisal procedures for the Otorhinolaryngology Services;
k) education on Patient Centred Care;
l) education on MSQH Standards requirements.
m) information about care and treatment to limit barriers such as accessibility, languages, spiritual and cultural beliefs etc;
n) educate on management of clinical alarm system, Occupational safety and health and fire safety.

EVIDENCE OF COMPLIANCE
1. Policy requiring all new staff to attend a structured orientation programme — NA
2. There is Surgical Services orientation programme with relevant topics not limited to topics covered from (a) to (l). — NA
3. Attendance list — NA</td><td>NA</td><td></td><td></td><td>NA</td><td></td></tr>
</table>

TOPIC TOPIC 9H.3
POLICIES AND PROCEDURES

STANDARD STANDARD 9H.3.1
DEVELOPMENT, DERIVATION AND DOCUMENTATION
There are written and dated policies and procedures for all activities of the Otorhinolaryngology Service. These policies and procedures reflect current standards of medical practice, relevant regulations, statutory requirements, and the purposes of the services. These policies and procedures, terms of reference, by-laws, rules or regulations, state how the clinical staff including medical practitioners regulate themselves and provide patient care.

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
9H.3.1.1 CORE	There are written policies and procedures for the Otorhinolaryngology Service which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated. There is a mechanism for and evidence of a periodic review at least once in every three years.	NA			NA	
	EVIDENCE OF COMPLIANCE					
	1. Documented policies and procedures for the service. — NA					
	2. Policies and procedures are consistent with regulatory requirements and current standard practices. — NA					
	3. Evidence of periodic review of policies and procedures. — NA					
	4. The policies and procedures are endorsed and dated. — NA					
9H.3.1.2	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved. Cross departmental collaboration with Allied Health Services (speech and audiology) is practised in developing relevant policies and procedures where applicable.	NA			NA	
	EVIDENCE OF COMPLIANCE					
	1. Minutes of committee meetings on development and revision on policies and procedures. — NA					
	2. Minutes of meeting with evidence of cross reference with other departments — NA					
	3. Documented cross departmental policies — NA					

9H.3.1.3 CORE	The policies and procedures documentation shall address at least the following topics and any others as required by relevant standards and laws: a) description of the organisational structure and operational policy of the Otorhinolaryngology Service; b) clinical practice guidelines; c) clinical documentation includes pain as the 5th vital sign where appropriate; d) handover communication; e) drug prescription, dispensing and administration; f) blood transfusion; g) continuing of care including regular review of patient, review of investigation results, discharge (planned or At Own Risk), referrals and escort as necessary; h) pain management; i) management of patients under police custody/prisoner; j) management of cases with an infectious disease including notification of notifiable diseases; k) the responsibilities of the staff including medical practitioners in relation to internal and external disasters are documented, and known to the staff (contingency plan); l) incident reports shall be compiled, investigated, discussed and recorded and action plans implemented; l) end of life care; m) management of a death; n) safe use of optical radiation devices, eg :LASER ; o) sedation policy and procedures; p) management of high risk patients or high risk services – emergency, comatose, immunosuppressive, on life support, on dialysis, with communicable disease, in restraints, receiving chemotherapy, vulnerable patients and palliative care q) Management of patient with implantable medical devices (Hearing aid, Cochlear implant, implantable hearing aid) r) Prescription and procurement of medical devices such as hearing aid and CPAP Machine s) Guidelines on Safe Surgery Saves Lives program. EVIDENCE OF COMPLIANCE 1. Documented policies and procedures that address but not limited to items (a) to (t). — NA	NA			NA	
9H.3.1.4	Current policies and procedures are communicated to all staff. EVIDENCE OF COMPLIANCE	NA			NA	

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

TOPIC TOPIC 9H.4
FACILITIES AND EQUIPMENT

STANDARD STANDARD 9H.4.1
The Head of Otorhinolaryngology Service shall ensure adequate facilities and equipment that are safe and appropriate are available for the staff to function effectively and to meet the goals and objectives of the Surgical Services.

CRITERION NO.	CRITERIA FOR COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
9H.4.1.1	There are adequate and appropriate facilities and equipment with proper utilisation of space to enable staff to carry out their professional, teaching and administrative functions.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Adequate and proper utilisation of space.	NA				
	2.	Appropriate type of equipments to match the complexity of services and subspecialties (emergencies and non emergencies)	NA				
	3.	Adequate facilities and equipment at each patient care area for safe care. (e.g. defibrillators, emergency cart, hand washing facilities etc)	NA				
	4.	Easy access and clear exit routes	NA				
	5.	Absence of overcrowding	NA				
9H.4.1.2	Existing facilities shall take safety consideration of staffs and patients.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Design and layout of the unit, e.g. wards, treatment rooms, dirty and clean utility rooms, access, lighting, signage, etc address the safety aspects of patients and staff.	NA				
	2.	Adequate equipment and supplies for Otorhinolaryngology Service, e.g. emergency trolley, functioning patient call bell, etc.	NA				
	3.	Equipment should have scheduled planned preventive maintenance (PPM).	NA				
9H.4.1.3	Suitable and adequate forms of communication and intercommunication systems and		NA			NA	

	equipment are provided to enable clinical staff to communicate among themselves and with the other members of the healthcare team. EVIDENCE OF COMPLIANCE 1. Effective telecommunication modalities available for daily operation and during emergencies. NA						

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

CRITERION NO.	CRITERIA FOR COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
9H.4.2.1	Facilities are suitably located to facilitate easy access and to provide an atmosphere of user, environmental and 'disabled' friendly.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Floor plan indicates accessibility and patient and user friendly.	NA				
	2.	Feedback from patient satisfaction survey	NA				
	3.	Incident reporting relating to facilities if any	NA				
9H.4.2.2	Equipment, both for emergency and non-emergency usage, shall be appropriate to the level of care.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Availability of emergency and non-emergency equipment appropriate to level of care, such as defibrillator, emergency trolley, suction machine, electrocardiogram (ECG) machine, infusion or syringe pump, vital sign monitor, tracheostomy set and tubes, endocopes, bronchoscopes etc.	NA				
	2.	Scheduled checking of items in emergency trolley	NA				
	3.	Disinfection procedure/protocol of equipments (scopes , forceps etc)	NA				
	4.	dedicated area for dirty and clean procedure	NA				
9H.4.2.3	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Testing, commissioning and calibration records (certificates or stickers)	NA				

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

STANDARD STANDARD 9H.4.3

FACILITIES FOR OTORHINOLARYNGOLOGY 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.

CRITERION NO.	CRITERIA FOR COMPLIANCE			SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
9H.4.3.1	The Specialist Outpatient Services shall have the following features: a) the organisation and management of the clinics are planned so as to ensure prompt attention to patients, minimal waiting time, and avoidance of unnecessary visits by the patients; b) record keeping shall be efficient; c) an appointment or queuing system is used to manage patient consultations; d) the clinic is easily accessible including for non-ambulant patients and is easily identified through adequate signage; e) the clinic is located easily accessible to other facilities, e.g. radiology, laboratories and pharmacy; f) adequate provision is made for patient comfort.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	The Specialist Outpatient Services address (a) to (f) with evidence of but not limited to the following:						
	a)	list of services available and offered to patients;	NA					
	b)	flow chart on work process;	NA					
	c)	safe keeping of medical records;	NA					
	d)	security of data in Health Information System	NA					
	e)	clinic appointment system;	NA					
	f)	monitoring of waiting time;	NA					
	g)	adequate and appropriate signage;	NA					
	h)	floor plan indicates accessibility to supporting services and optimisation of space;	NA					
	i)	adequate patient personal use items, e.g. wheelchair, etc;	NA					

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

TOPIC TOPIC 9H.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD STANDARD 9H.5.1
The Head of Otorhinolaryngology Service shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Services. The Head of Otorhinolaryngology Service shall ensure compliance to monitoring of specific performance indicators.

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
9H.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Otorhinolaryngology Services. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.	NA			NA	
	EVIDENCE OF COMPLIANCE					
	1. Planned performance improvement activities include (a) to (f) — NA 2. Records on performance improvement activities — NA 3. Minutes of performance improvement meetings — NA 4. Performance improvement studies — NA 5. Mortality and morbidity audits, POMR reporting status, with remedial actions — NA 6. Records on innovation if available. — NA 7. Record on the Management of complaints/feedbacks — NA					
9H.5.1.2	The Head of Otorhinolaryngology Service has assigned the responsibilities for planning, monitoring and managing safety and performance improvement activities to appropriate individual / personnel within the respective services.	NA			NA	

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

	b) Whatever structure is utilised, provision is made for review and analysis of the clinical work of each individual clinical service, department, unit or function. EVIDENCE OF COMPLIANCE 1. Performance improvement activities — NA 2. Minutes of meetings — NA 3. Relevant reports and documents, e.g. clinical audit reports, incident reports, mortality and morbidity review reports, etc. — NA 4. Risk registry/risk management activities — NA					
9H.5.1.5 CORE	There is tracking and trending of specific performance indicators not limited to but at least two (2) of the following: a) number of mortality/morbidity audits/meetings being conducted in the department with documentation of cases discussed b) percentage of unplanned re-admission within 72 hours of discharge c) unplanned return to operating theatre within the same hospital admission following surgery d) ≥ 90% of patients with waiting time of ≤ 90 minutes to see the doctor at Otorhinolaryngology (ORL) Clinic e) Improvement of hearing following myringoplasty ≥ 70% f) Incidence of primary post tonsillectomy haemorrhage ≤ 3% EVIDENCE OF COMPLIANCE 1. Specific performance indicators monitored. — NA 2. Records on tracking and trending analysis. — NA 3. Minutes of mortality/morbidity audits meetings — NA 4. Remedial measures taken where appropriate — NA	NA			NA	
9H.5.1.6	Feedback on results of safety and performance improvement activities are regularly communicated to the staff. EVIDENCE OF COMPLIANCE 1. Results on safety and performance improvement activities are accessible to staff. — NA 2. Evidence of feedback via communication on results of performance improvement activities through continuing medical education/meetings. — NA 3. Minutes of service/unit/committee meetings — NA	NA			NA	

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

SERVICE SUMMARY	
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OVERALL RATING :	NA
OVERALL RISK :	-