SERVICE STANDARD 08: EMERGENCY SERVICES

PREAMBLE

The Facility shall provide Emergency Services, which shall be accessible and operational on a 24-hour basis. Any individual presenting with perceived or real emergencies arising from any injury or illness has the right to attend the Emergency Services. The Emergency Services shall extend and not refuse care that is deemed clinically necessary to any patient presenting with genuine emergencies to the Emergency Services. The Facility shall identify the scope of Emergency Services to be provided. When or where the services are not available or exceeding its scope, there is a policy regarding referral to a facility equipped with such services to render optimum care to the patient.

TOPIC 8.1:
ORGANISATION AND MANAGEMENT

STANDARD 8.1.1

The Emergency Services shall provide quality care which shall be organised, directed and coordinated with other services in the Facility according to the goals and objectives of the Facility to meet the needs of the patient population being served.

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
8.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Emergency Services are clearly documented and measurable that indicates safety, quality and patient centred care. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.	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 Emergency 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					
8.1.1.2 CORE	There is an organisation chart which:	NA			NA	

	a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head of the Emergency Services, consultants, medical practitioners and staff of the Emergency Services; b) is accessible to all staff and clients; c) is revised when there is a major change in any of the following: i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns. **EVIDENCE OF COMPLIANCE** 1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head of the Emergency Services, consultants, medical practitioners and staff of the Emergency Services. — 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 (c)(i) to (iv). — NA					
8.1.1.3	Staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Emergency Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented. **EVIDENCE OF COMPLIANCE** 1. Minutes are accessible, disseminated and acknowledged by the staff. — NA 2. Attendance list of members with adequate representatives of the service. — NA 3. Frequency of meetings are as scheduled. — NA 4. Matters requiring action are taken, reported and documented. Pending matters are accounted for and pursued. — NA	NA			NA	
8.1.1.4	The Head of the Emergency Services is involved in clinical governance and patient management. **EVIDENCE OF COMPLIANCE** 1. Appropriate meetings for the department, unit or committee are chaired by Head of Emergency Services. — NA 2. Clinical processes are endorsed by the Head of Emergency Services. — NA	NA			NA	

8.1.1.5	The Head of Emergency Services is involved in the planning, justification and management of the budget and resources of the services. EVIDENCE OF COMPLIANCE 1. Minutes of Facility-wide management meeting. — NA 2. Documented evidence on budget and resources (staffing, equipment, etc) request and allocation for the service. — NA 3. Approved budget and resources. — NA	NA			NA	
8.1.1.6	The Head of the Emergency Services is involved in the appointment and/OR assignment of the staff. EVIDENCE OF COMPLIANCE 1. Records on staff interview (if applicable) — NA 2. Appointment/assignment letter of Head of Service — NA 3. Job description of Head of Service — NA 4. Records on staff deployment — NA 5. Duty roster — NA	NA			NA	
8.1.1.7	Appropriate statistics and records shall be maintained in relation to the provision of Emergency Services and used for managing the services and patient care purposes. EVIDENCE OF COMPLIANCE 1. Records are available but not limited to the following: a) workload/census; — NA b) annual report; — NA c) accident/incident reports; — NA d) staffing number and staff profile; — NA e) staff training records; — NA f) data on performance improvement activities, including performance indicators. — NA	NA			NA	
8.1.1.8	Where the Emergency Services provides clinical experience for students of medicine and paramedical sciences, a comprehensive documented agreement between the Facility and the educational institution shall exist detailing the responsibilities of all parties including: a) time period;	NA			NA	

b) liability;
c) terms of contract review;
d) accountability for training and clinical practice.

EVIDENCE OF COMPLIANCE		
1.	Valid letter of intent or request/posting and assigned supervisor	NA
2.	Ratio of Clinical Instructor (CI) and students commensurate with the number of students	NA
3.	Student allocation roster or programme	NA

STANDARD 8.1.2

CONTINUITY OF CARE

The department shall provide patient triage, clinical assessment, perform necessary investigation and intervention based on the clinical needs of patient. The emergency care provided will include resuscitation, stabilization and therapeutics. When clinically indicated or the threshold is met, patient shall be referred to other clinical service(s) for further medical care. When definitive care of the patient requires a team approach, the clinical discipline taking a leading patient care role shall be determined by the department. The facility will also ensure the continuity of care is maintained during patient transfer from the emergency department to other parts of the facility.

Where the Facility does not have the facilities or medical ability to render optimum care to the patient, arrangements shall be made for transfer to another facility or appropriate treatment centre after initial emergency care.

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
8.1.2.1 CORE	Where the Facility does not have the facilities or medical ability to render optimum care to the patient, arrangements shall be made for transfer to another facility or more appropriate treatment centre When arranging for patient to be transferred to a receiving facility, there is evidence that: a) communication between the facilities is established by the relevant discipline and the transfer is mutually agreed; b) appropriately qualified staff(s) accompanies the patient; c) relevant patient clinical details is documented, communicated to the accompanying staff and the receiving team; d) continuity of care is ensured throughout this process; EVIDENCE OF COMPLIANCE 1. Copy of referral letter is available. — NA 2. Contents in the referral letter are appropriately written and includes acceptance of the patient by the referred facility, name of the receiving person and designation — NA 3. Ambulance transfer form, in-transit and hand-over records — NA	NA			NA	
8.1.2.2	Close working and formal arrangements shall exist between the Emergency Services and appropriate parties: a) Internally with: i) other clinical services of the Facility; ii) support services including cleansing, security; iii) non-clinical functions of the Emergency Services, i.e. reception, registration/ payment/billing and clerical services. b) Externally with other local healthcare agencies operating within the Facility's catchment area including feeder clinics or facilities.	NA			NA	

	EVIDENCE OF COMPLIANCE					
	1.	Evidence of close working arrangement between the service and other parties such as cross departmental policy, standard operating procedures (SOP), key process(s) of services within the Facility.	NA			
	2.	Minutes of meetings or discussions	NA			
	3.	Relevant documents on coordination, policy, Memorandum of Understanding or Agreement	NA			
8.1.2.3	When the ambulance service or other patient transport services is utilised: a) the procedure is done in a coordinated manner; b) medical oversight is provided by the referring facility; c) Continuity of physician directive during the transport is ensured. d) Shall be accompanied by appropriate and competent health care provider		NA			NA
	EVIDENCE OF COMPLIANCE					
	1.	Ambulance transfer form and records	NA			
	2.	Relevant documents on coordination, policy, Memorandum of Understanding or Agreement.	NA			
	3.	Validation on continuity of physician's orders during transport from staff interview.	NA			
8.1.2.4	The Emergency Services shall state its role in internal and external emergency or disaster plans of the Facility (or for the community), e.g. Medical Emergency Team (Code Blue), mass casualty incident.		NA			NA
	EVIDENCE OF COMPLIANCE					
	1.	Membership in the Facility's risk management and disaster planning committee	NA			
	2.	Involvement in the policy and Standard Operating Procedures development for internal and external disasters.	NA			
	3.	Incident and disaster drill documentation reports	NA			

TOPIC 8.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD 8.2.1
The Emergency Services shall be under the supervision of a registered medical practitioner with training and experience in emergency medicine. It shall be staffed with appropriately qualified and licensed personnel to achieve the goals and objectives of the services.

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
8.2.1.1 CORE	The Head of the Emergency Services shall be an emergency physician who is a individual qualified by education, training, experience and certification to commensurate with the requirements of the various positions and is NSR (Emergency Medicine) registered. All Emergency Services without resident emergency specialist shall have a visiting Emergency Physician or resident specialist who supervises the Emergency Services. Number / frequency of emergency specialist visit depend on capacity and capability of state determined by head of service of the state or by CEO/PIC EVIDENCE OF COMPLIANCE 1. Records on credentials of Head of Service and staff required to fill up the posts within the service (to match the complexity of the Facility and services) and certification/registration. — NA 2. Appointment/assignment letters. — NA 3. Certification. — NA 4. Training and competency records. — NA 5. Valid professional Annual Practising Certificate (APC) and registered with NSR — NA 6. Documentation of visits of the Emergency Physician. — NA	NA			NA	
8.2.1.2	The authority, responsibilities and accountabilities of the Head of Emergency Services are clearly delineated and documented in a letter of appointment. EVIDENCE OF COMPLIANCE 1. Appointment/assignment letter for Head of Service. — NA 2. Description of duties and responsibilities — NA	NA			NA	

8.2.1.3	Sufficient numbers of personnel and support staff with appropriate qualifications are employed to enable the services to meet the documented purposes. EVIDENCE OF COMPLIANCE 1. Compliance with norms of current Emergency Medicine Trauma Services Policy of the Ministry of Heath where applicable. — NA 2. Number of staff and qualification should commensurate with workload. — NA 3. Staffing pattern — NA 4. Duty roster — NA 5. Census and statistics — NA	NA			NA	
8.2.1.4	There are written and dated specific job descriptions for all categories of staff that include: a) qualifications, training, experience and certification required for the position; b) lines of authority; c) accountability, functions, and responsibilities; d) reviewed when required and when there is a major change in any of the following: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations. e) administrative and clinical functions. EVIDENCE OF COMPLIANCE 1. Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e) for the proper functioning of the Emergency Services. — NA 2. Job description includes specialisation skills — NA 3. Relevant privileges granted where applicable — NA 4. The nature and scope of work of each staff is specified. — NA 5. The job description is acknowledged by the staff and signed by the Head of Service and dated. — NA	NA			NA	
8.2.1.5	Personnel records on training, staff development, leave and others are maintained for every staff. Note:	NA			NA	

	Staff personal record may be kept in Human Resource Department as per Facility policy. **EVIDENCE OF COMPLIANCE** 1. Staff personal records include: a) staff biodata; NA b) qualification and experience; NA c) evidence of current registration; NA d) training record; NA e) competency record and privileging; NA f) leave record; NA g) confidentiality agreement. NA					
8.2.1.6	There are continuing education activities for staff including medical practitioners to pursue professional interests and to prepare for current and future changes in practice. **EVIDENCE OF COMPLIANCE** 1. Training calendar includes in-house/external courses/ workshop/conferences NA 2. Contents of training programme NA 3. Training records on continuing education activities are kept and maintained for each staff. NA 4. Certificate of attendance/degree/post basic training. NA	NA			NA	
8.2.1.7	There is evidence of a training needs assessment and staff development plan which provides the knowledge and skills required for staff to maintain competency in their current positions and future advancement. **EVIDENCE OF COMPLIANCE** 1. Training needs assessment is carried out and gaps identified. 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	NA			NA	
8.2.1.8	There is a structured orientation programme for all newly appointed staff to the Emergency Services including medical practitioners and for those new to specific areas that include the following:	NA			NA	

	a) explanation of the philosophy, goals, objectives, policies and procedures of the Facility and those of the Emergency Services; b) lines of authority and areas of responsibility; c) explanation of particular duties and functions; d) explanation of the methods of assigning emergency care, and the standards of emergency practice; e) handover communication; f) processes for resolving practice dilemmas; g) information about safety procedures; h) training in basic/ advanced life support techniques; i) methods of obtaining appropriate resource materials; j) staff appraisal procedures for the Emergency Services; k) education on Patient and Family Rights; l) education on MSQH Standards requirements. EVIDENCE OF COMPLIANCE 1. Policy requiring all new staff to attend a structured orientation programme. — NA 2. There is Emergency Services orientation programme with relevant topics not limited to topics covered from (a) to (l). — NA 3. Attendance list — NA					
8.2.1.9	Staff including medical practitioners receive written evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility. EVIDENCE OF COMPLIANCE 1. Performance appraisal for staff including medical practitioners is completed and acted upon appropriately upon probationary period and as an annual exercise. — NA	NA			NA	

TOPIC 8.3:
POLICIES AND PROCEDURES

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

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
8.3.1.1 CORE	Triage shall be performed by a medical practitioner or a paramedical staff trained in triage practice and directs the patient to the appropriate zoning area taking into account the degree of urgency and clinical condition of the patient. **EVIDENCE OF COMPLIANCE** 1. Triage flow and standard operating procedures (SOP) — NA 2. Triage training certificate and log book — NA 3. Records on continuing medical education activities for staff. — NA	NA			NA	
8.3.1.2	The zoning of clinical areas reflective of patient severity/acuity shall be well demarcated and functionally appropriate to the degree of urgency and clinical condition of the patient. **EVIDENCE OF COMPLIANCE** 1. Zoning of clinical areas is reflective of patient severity/acuity — NA 2. Triage category is observed and complied in practice. — NA	NA			NA	
8.3.1.3	Action plans and policy for the appropriate cohorting, isolation and decontamination of patients suspected or confirm with highly infectious disease or expose to hazardous material shall be available. **EVIDENCE OF COMPLIANCE** 1. Policy on management of infectious diseases and outbreak in Emergency Services — NA 2. Identified areas/structures for cohorting, isolation and decontamination of patients suspected of infectious disease — NA 3. Area use for isolation of patient suspected or confirm with highly infectious disease must be compliance to Infection Prevention and — NA	NA			NA	

		Control (IPC), WHO and engineering requirement by Ministry of Health, Malaysia.						

STANDARD 8.3.2

Documented policies and procedures shall reflect current knowledge and evidence based practices for the services; and they are consistent with the objectives of the services and relevant regulations and statutory requirements.

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
8.3.2.1 CORE	There are written policies and procedures for the Emergency Services which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated. There is a mechanism for and evidence of a periodic review at least once in every three years.	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					
8.3.2.2	Policies and procedures are developed in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved. Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.	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					
8.3.2.3	Current policies and procedures are communicated to all staff.	NA			NA	
	EVIDENCE OF COMPLIANCE					
	1. Training and briefing on the current policies and procedures/Minutes of meetings — NA					

	2.	Circulation list and acknowledgement	NA				
8.3.2.4 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 evidenced upon on-site inspection.	NA					
8.3.2.5	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 policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.	NA					
8.3.2.6	There will be a working relationship between the emergency department and relevant emergency services such as police, fire and rescue, MERS 999, civil defense, other ambulance agencies and/or local disaster agencies etc			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Minutes/report of inter departmental/ inter agency meetings and training: such as disaster table top exercise, interagency life support training etc.	NA					
	2.	Shared workflow and standard operating procedures, i.e. for abuse cases under One Stop Crisis Center (OSCC), external and internal disaster response plan and etc.	NA					
8.3.2.7	All patients shall be correctly identified from arrival at the Emergency Services by use of Health Information Management System including patients unable to provide personal information on their own.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Patient identification policy, process and workflow	NA					
	2.	Patient identification (medical record number)	NA					

	3.	Patient identification tag for unconscious and unknown identity patients.	NA				
8.3.2.8	Where staff provide direct care to patients, documentation is made in the patient's medical record that care has been given. Where appropriate, response to care is recorded by the care provider; signed, dated and designation documented.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Patient care forms	NA				
	2.	Patient medical records	NA				
	3.	Drug prescription form	NA				
8.3.2.9	Seriously ill patients shall have appropriate monitoring, observation with clinical documentation available at all times. There shall be a policy stating which patients shall be admitted and which patients can be observed in the emergency room; and expected duration before patient is admitted, e.g. patients requiring ventilation support, severe burns shall be admitted.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Appropriateness of triage category for seriously ill patient	NA				
	2.	Policy for observation and monitoring according to patient severity and care area	NA				
	3.	Nursing care notes and documentation	NA				
8.3.2.10	Appropriate escort personnel and equipment shall follow patient during intra or out of service movements taking into consideration the patient disease or injury severity.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Standard operating procedures and observation of compliance.	NA				
8.3.2.11	For Emergency Services having patients intentionally cared in its environment for extended periods, such as dedicated patient observation area or short stay unit, there shall be a documented policy/ guidelines on the operational definitions, clinical criterias, permissible duration of stay and accountability. When admitted patients are unintentionally cared in the Emergency Services environment beyond reasonable period, this is addressed as a situation that is, or will potentially lead to shortfall in care in the facility; notwithstanding, continuity of clinical care is ensured, patient needs and rights are met.			NA			NA	
	EVIDENCE OF COMPLIANCE							

	1.	Policy/ guidelines for observation area/ short stay unit or ward	NA					
	2.	Institution policy/standards for unintentional extended stay in the Emergency Services environment	NA					
	3.	Length of stay performance / statistics for admitted patient in emergency services; Incident reports for unintentional extended stay	NA					
	4.	Patient care documents ie: regularity of doctor review and management, nursing care report incl. vital sign monitoring etc..	NA					

TOPIC 8.4:
FACILITIES AND EQUIPMENT

STANDARD 8.4.1
Appropriate facilities and lifesaving equipment are available to enable the Emergency Services to meet its goals and objectives to provide safe, effective and efficient emergency care.

<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>8.4.1.1</td><td>The Emergency Services shall have dedicated treatment zones based on activity. The zone shall be clearly visible with directional signage which is well posted. Access to each area shall be determine it function and maybe restricted from public based on needs.
a) Patient drop zone and triage area
b) Reception, registration and waiting area
c) Resuscitation and critical care area
d) Semi-critical area
e) Non-critical area
f) Procedural and specialty care area for example: plaster room, minor operation theatre and etc.
g) Patient isolation and decontamination area
h) Others (when applicable)
• Ambulance Communication Centre
• Ambulance drop zone and access
i) Storage (consumable, equipment and disaster) cross reference with standard 2 for disaster, common storage area
<table><tr><th colspan="3">EVIDENCE OF COMPLIANCE</th></tr><tr><td>1.</td><td>The design and layout of the emergency department shall include features as listed.</td><td>NA</td></tr><tr><td>2.</td><td>Policies on access safety and capacity of clinical area.</td><td>NA</td></tr><tr><td>3.</td><td>Facility action plan should clinical area exceeds its patient capacity limit at any one time.</td><td>NA</td></tr><tr><td>4.</td><td>Patient journey experience (interview)</td><td>NA</td></tr></table></td><td>NA</td><td></td><td></td><td>NA</td><td></td></tr>
<tr><td>8.4.1.2</td><td>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.</td><td>NA</td><td></td><td></td><td>NA</td><td></td></tr>
</table>

	EVIDENCE OF COMPLIANCE						
	1.	Adequate and proper utilisation of space.	NA				
	2.	Appropriate type of equipment to match the complexity of services.	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				
8.4.1.3	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.	Certificates of calibration, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc.	NA				
8.4.1.4 CORE	There is evidence that the facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.			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				
8.4.1.5	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.			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				
8.4.1.6 CORE	The Emergency Services are equipped with the minimum requirements in terms of equipment. Additional equipment may be required to meet the goals and objectives of the			NA			NA	

	Emergency Services and the Facility depending on the level and scope of Emergency Services. Minimum requirements are: Equipment and other functionalities: a) Airway Management devices such as: i) Adjuncts:- oropharyngeal airway, nasopharyngeal airway; ii) Endotracheal Intubation Equipment; iii) Rescue airway devices for Difficult and failed airway situation i.e: supraglottic airway, Video Assisted Laryngoscope and devices. b) Oxygen Delivery Equipment such as; i) various size oxygen mask, simple face mask, venturi mask, high flow rebreathing mask c) Respiratory and ventilation Support such as; i) Ventilator invasive and non-invasive d) Vascular Access Devices and Circulatory Support including: i) Intravascular access devices including intraosseous set (manual/ mechanical) ii) Intravenous fluid delivery devises inclusive volumetric pump and rapid infusions iii) Various intravenous fluids solution for resuscitation and volume replacement. e) Defibrillator and Emergency Cardiac Care Equipment including i) 12 Lead ECG machine and Transcutaneous pacing depending on the level of care provided. ii) Defibrillator with Automated External Defibrillator (AED) capabilities. f) Patient Body Thermal Control Equipment g) Fluid Warmers, Storage for Blood products (depending on level of care; within easy access) h) Limb, Neck and Spine Immobilization and Protection Equipment i) Patient Vital Parameters Monitor including i) Blood Pressure, Pulse Rate, Respiratory Rate, Pulse oximetry, Cardiac Monitoring and temperature. j) Wounds, Soft tissue and Burns Care Sets k) Point of Care or Bedside (Rapid) Diagnostic Tests or Support including: i) blood sugar analyzer; ii) Urine analyzer. iii) Full blood count iv) Arterial blood gas v) Dengue test l) Bedside Imaging Devices or Support i) Access to portable X-ray; ii) Access to Ultrasound / portable ultrasound / point of care ultrasound m) Emergency Care Equipment for pediatric including length based chart/tape for equipment sizing and emergency drug dosing (Broselow Tape) n) Obstetric Delivery Equipment o) Emergency Patient Care Beds					

	EVIDENCE OF COMPLIANCE 1. On-site observation on availability of items (a) to (o) — NA 2. Credential and privileged medical officer in performing a (iii), d (i), l (ii) — NA					
8.4.1.7 CORE	Medications in formulations or form that reflect current standards and other accepted emergency and resuscitative care best practices, deemed necessary for it to optimally meet goals and objectives of the Emergency Services and the Facility. Minimum requirements are: a) Drugs in Resuscitation Cart but not limited to: i) Oxygen ii) Antianginal – at least Sublingual Glyceryl Trinitrate (GTN) iii) Antiarrythmics • Adenosine • Amiodarone • Lignocaine • Digoxin iv) Antidotes • Flumazenil • Naloxone v) Atropine vi) Glucose 50% vii) Magnesium Sulphate viii) Calcium Chloride or Gluconate ix) Sodium Bicarbonate x) Adrenaline xi) Water for injection b) Drugs to be kept as floor stock drug with easy availability but not limited to: i) Antihypertensives • ACE inhibitors • Beta Blockers – e.g.: labetolol • Calcium Channel blockers • Angiotensin II Receptor Blockers ii) Activated charcoal iii) Antihistamines • Chlopheniramine • prochlorperazine iv) Antiplatelets • Aspirin • Clopidogrel	NA			NA	

v) Bronchodilators : salbutamol/terbutaline, ipratropium brominde (alone and/or combination with salbutamol), Theophylline (aminophylline) and nebuliser preparations
vi) Corticosteroids
- Hydrocortisone, dexamethasone

vii) Inotropic drugs
- Dobutamine
- Dopamine
- Noradrenaline

viii) Analgesics
- NSAID
- OPIOD

ix) Anti-Convulsion
- Phenytoin sodium
- Midazolam
- Diazepam
- Lorazepam (optional)

EVIDENCE OF COMPLIANCE		
1.	On-site observation on availability of items (a)(i) to (a)(xi) and (b)(i) to (b)(ix)	NA

TOPIC 8.5:
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 8.5.1

The Head of Emergency Services shall ensure the provision of high quality performance with staff involvement in the ongoing safety and performance improvement activities of the Emergency Services.

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
8.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Emergency Services. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.	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 with remedial actions — NA					
	6. Records on innovation if available — NA					
8.5.1.2	The Head of Emergency Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement activities to appropriate individual/personnel within the respective services.	NA			NA	
	EVIDENCE OF COMPLIANCE					
	1. Minutes of meetings — NA					
	2. Letter of assignment of responsibilities — NA					
	3. Job description — NA					

<table>
<tr>
<td>8.5.1.3</td>
<td>The Head of Emergency Services shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility.
Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.

<table>
<tr><th colspan="3">EVIDENCE OF COMPLIANCE</th></tr>
<tr><td>1.</td><td colspan="2">System for incident reporting is in place, which include:</td></tr>
<tr><td>a)</td><td>Training of staff</td><td>NA</td></tr>
<tr><td>b)</td><td>Policy on incident reporting</td><td>NA</td></tr>
<tr><td>c)</td><td>Methodology of incident reporting</td><td>NA</td></tr>
<tr><td>d)</td><td>Register/records of incidents</td><td>NA</td></tr>
<tr><td>2.</td><td>Completed incident reports</td><td>NA</td></tr>
<tr><td>3.</td><td>Root Cause Analysis</td><td>NA</td></tr>
<tr><td>4.</td><td>Corrective and preventive action plans</td><td>NA</td></tr>
<tr><td>5.</td><td>Remedial measure</td><td>NA</td></tr>
<tr><td>6.</td><td>Minutes of meetings</td><td>NA</td></tr>
<tr><td>7.</td><td>Acknowledgment by Head of Service and PIC/Hospital Director</td><td>NA</td></tr>
<tr><td>8.</td><td>Feedback given to staff regarding incident reporting.</td><td>NA</td></tr>
</table>
</td>
<td>NA</td><td></td><td></td><td>NA</td><td></td>
</tr>
<tr>
<td>8.5.1.4
CORE</td>
<td>There is tracking and trending of specific performance indicators not limited to but at least two (2) of the following including the mandatory indicator:
a) Mandatory Indicator percentage of inappropriate triaging (under triaging): Category Green patients who should have been triaged as Category Red
(Target: ≤ 0.5%)
b) waiting time relative to Triage Category:
i) Malaysian Triage Category (MTC) Red seen immediately (Target: 100%)
ii) Malaysian Triage Category (MTC) Yellow seen within 30 minutes (Target: ≥85%)
iii) Malaysian Triage Category (MTC) Green seen within 90 minutes (> 70%)
c)
unplanned return of patient seen at Emergency Department within 24 hours for a similar complaint (sentinel event).

<table>
<tr><th colspan="3">EVIDENCE OF COMPLIANCE</th></tr>
<tr><td>1.</td><td>Specific performance indicators monitored.</td><td>NA</td></tr>
<tr><td>2.</td><td>Records on tracking and trending analysis.</td><td>NA</td></tr>
</table>
</td>
<td>NA</td><td></td><td></td><td>NA</td><td></td>
</tr>
</table>

	3.	Remedial measures taken where appropriate	NA				
8.5.1.5	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.			NA		NA	
	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 meetings	NA				
8.5.1.6	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 :	-