SERVICE STANDARD 09: CLINICAL SERVICES - NON-SPECIALIST FACILITY

PREAMBLE

Clinical Services play an integral role in delivering appropriate care and reducing unwarranted adverse events, as they meet the care people expect to be offered or receive, regardless of where they are treated in the Facility. The Clinical Services shall be organised, directed and coordinated with other services in the Facility to provide a high standard of inpatient and outpatient care to the community and address the following: a) appropriateness of clinical care; b) unwarranted variation in care that is not explained by the clinical circumstances or personal choices of the medical practitioners in: i) overuse of treatments or procedures that do not help patient get better; ii) underuse of care; iii) Misuse (or errors) of doing something incorrectly and harming patients. In addition to the above, the Clinical Services also conduct teaching and training, research and audit activities where applicable.

TOPIC 9.1
ORGANISATION AND MANAGEMENT

STANDARD 9.1.1

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

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

<table>
<tr>
<td>CORE</td>
<td>a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head of Clinical Services, medical practitioners and staff of the Clinical Services;
b) is accessible to all staff and clients;
c) is revised when there is a major change in any of the following:
i) organisation;
ii) functions;
iii) reporting relationships;
iv) Staffing patterns.
d) where applicable, the chart should also reflect the clustering hospitals (between Lead & Non Lead)

EVIDENCE OF COMPLIANCE
1. Clearly delineated current organisation chart with line of functions and reporting relationships between Person In Charge (PIC), Head of Clinical Services, medical practitioners and staff of the Clinical Services. — NA
2. Organisation chart of the serviceis 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
4. Clustering hospital representation is shown in organization chart — NA</td>
<td></td><td></td><td></td><td></td>
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<tr>
<td>9.1.1.3</td>
<td>The Governing Body shall ensure that the Clinical Services are organised in such a way as to:
a) facilitate the provision of clinical services to patients in the Facility in a safe, efficient, effective and caring manner and with due regard for the needs, dignity and privacy of patients and confidentiality of their personal information;
b) assure continuity of care;
c) address the professional needs of the medical practitioners;
d) ensure that the medical practitioners are involved in the formulation of policies and procedures concerning patient care appropriate to the scope of services of the Facility.

EVIDENCE OF COMPLIANCE
1. Departmental/Service operational policies that address (a) to (d). — 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</td>
<td>NA</td><td></td><td></td><td>NA</td><td></td>
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</table>

	4.	Involvement of Head of the Service in the Clinical Staff Committee and ward meetings	NA				
	5.	Minutes of meetings	NA				
	6.	Proper and adequate equipment according to current standards.	NA				
9.1.1.4	There is a mechanism to ensure effective interaction between the Clinical Services and the Governing Body on all clinical aspects of healthcare and other relevant matters in the Facility. This mechanism is defined in the policies of the Governing Body and is accomplished through: a) the appointment of a medical practitioner(s) as the Head of Clinical Services delineating his/her authority, responsibilities and accountabilities in a written document according to the relevant Acts to manage and control the clinical services; b) Clinical Staff Committee to provide input to the Governing Body on issues related to clinical governance, i.e. planning, coordinating, implementation, control and to improve activities relating to Clinical Services. Note: *Clinical Staff Committee comprises of medical practitioners from clinical disciplines in the Facility and chaired by the Hospital Director.*		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Letter of appointment/assignment and delineation of duties and responsibilities of the Head of the Service.	NA				
	2.	Letter of appointment and Terms of Reference as member of the Clinical Staff Committee.	NA				
	3.	Minutes of meetings	NA				
9.1.1.5 CORE	The Head of Clinical Services has: a) to be a registered medical practitioner b) representation of the Service in committees and subcommittees where relevant; c) representation of the Service in clinical staff liaison meetings; d) Involvement and provide regular input to the Senior Management Team.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Letter of assignment from governing body	NA				
	2.	Letter of representation of the Head of Service in committees and subcommittees where relevant, e.g. Blood Transfusion Committee,	NA				

		Medical Records Committee, Hospital Infection and Antibiotic Control Committee, etc.					
	3.	Minutes of meetings of committees	NA				
	4.	Minutes of meeting of Senior Management Team	NA				
9.1.1.6	The assessment, planning, direction, evaluation and continuity of clinical care are the responsibility of medical practitioners managing individual patients, thus ensuring clinical independence and patient centered care.			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				
	3.	Policy and procedures are available to ensure patient centered care	NA				
9.1.1.7	The Head of Clinical Services shall be involved for the following aspects of management of the services: a) the preparation of budget and ensuring that expenditure remains within the budget allocated; b) human resource management and development; c) development of policies and procedures and ensuring compliance to them; d) facility and equipment management; e) safety and performance improvement activities and risk management.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Evidence of (a) to (e) in the minutes of meetings of Clinical Services (Senior Management Team) indicate the involvement of Head of Service.	NA				
	2.	Endorsement of policies and procedures	NA				
	3.	Request for allocation of budget and staffing	NA				
	4.	Implementation of performance improvement activities	NA				
9.1.1.8	Regular staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Clinical Services. Minutes are kept; decisions and resolutions made during			NA			NA	

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

TOPIC 9.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD 9.2.1
CREDENTIALING AND PRIVILEGING
The Clinical Services shall be directed by a qualified and competent medical practitioner, and staffed by suitably qualified and competent clinical staff to achieve the goals and objectives of the Clinical Services.

<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>9.2.1.1
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;
f) peer recommendations are taken into account when privileges are being considered;
g) the recommendations of the relevant department and/or major professional services for privileges to be granted are taken into consideration.
h) All staff under cluster hospital where applicable shall be privileged in the applicable hospital in their respective services

EVIDENCE OF COMPLIANCE
1. Documented policies and procedures are established to govern the credentialing and privileging processes which include items (a) to (g). — NA
2. Compliance with policy and criteria for credentialing and privileging — NA
3. Competency records/log books — NA
4. Recommendations from peer/referee — NA</td><td>NA</td><td></td><td></td><td>NA</td><td></td></tr>
</table>

	5.	Annual Practising Certificate (APC)	NA				
	6.	Privileging certificates which include Lead and Non-lead cluster hospital (where applicable)	NA				
	7.	Availability of the list of procedures requiring privileging.	NA				
	8.	Availability of list of procedures to include core procedures specific to the disciplines performed by medical officers.	NA				
9.2.1.2 CORE	Documented evidence of privileges conferred by the Governing Body is available and accessible to relevant staff at point of care.			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				
9.2.1.3	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				
9.2.1.4	There are written and dated specific job descriptions for all categories of staff that include: a) qualification, training, experience and certification required for the position; b) lines of authority; c) accountability, functions, and responsibilities; d) reviewed when required and when there is a major change in any of the following: 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 9.2.2
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
9.2.2.1	The facility shall establish a Competency Development Framework (CDF) which is consistent with the service to be provided and delivered in order to achieve a quality and safe care.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	A Competency Development Framework checklist	NA				
	2.	The checklist should address the adequacy & appropriateness of staff education , training & experience	NA				
9.2.2.2 CORE	There is evidence of training needs assessment and staff development plan which provide the knowledge and skills required for staff to maintain competency in their current positions and future advancement.		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				
9.2.2.3	There are continuing education activities for staff including medical practitioners to pursue professional interests and to prepare for current and future changes in practice.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Training calendar include 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				
9.2.2.4	The educational needs of staff and the Facility, as evidenced by the results of medical- care evaluation such as incident reports, performance improvement studies and complaints, are taken into consideration when the content and structure of educational activities are planned.			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					
9.2.2.5	Staff including medical practitioners receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Performance appraisal for staff including medical practitioners is completed upon probationary period and as an annual exercise.	NA					
9.2.2.6	The Facility shall ensure that the staffs are trained in aspect of patient centered care.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Documented evidence of training.	NA					
9.2.2.7	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, etc.	NA					

STANDARD 9.2.3

STAFFING LEVEL AND STAFF COMPETENCY

The Head and staff of the Clinical Services including medical practitioners are individuals qualified by education, training and experience 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
9.2.3.1	Deployment of all service providers for any clinical service takes the following factors into consideration: a) the number of persons deployed is proportional to the number of patients being cared for as in the regulatory requirements and for the intensity of care provided; b) the categories of service providers based on qualifications and experience providing care reflect the complexity of clinical problems being managed; c) staffing needs shall take into consideration absences due to leave or illness; double shift duties by clinical staff shall be documented and monitored; d) adequate staffing levels of appropriate competency shall be maintained throughout the hours the services are in operation. Where services need to be provided on a 24-hour basis, staffing level reflects the intensity of activities during each shift; e) where it is not possible to have service providers on duty on site, e.g. after working hours, provision is made for relevant medical practitioner to be available on call.			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 9.2.4

STAFF ORIENTATION

A structured orientation programme introduces new staff to their services, operational policies and relevant aspects of the Facility to prepare them for their roles and responsibilities.

<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>
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<tr><td>9.2.4.1</td><td>There is a structured orientation programme for all newly appointed staff to the Clinical Services including medical practitioners and for those new to specific areas that include the following:
a) explanation of the goals, objectives, policies and procedures of the Facility and those of the Clinical Services;
b) lines of authority and areas of responsibility;
c) explanation of particular duties and functions;
d) explanation of the methods of assigning clinical care and the standards of clinical practice;
e) handover communication;
f) processes for resolving practice/ethical dilemmas in a timely manner;
g) information about safety procedures;
h) training in basic/advanced life support techniques;
i) methods of obtaining appropriate resource materials;
j) staff appraisal procedures for the Clinical 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 Clinical 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 9.3
POLICIES AND PROCEDURES

STANDARD 9.3.1
DEVELOPMENT, DERIVATION AND DOCUMENTATION There are written and dated policies and procedures for all activities of the Clinical Services. 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
9.3.1.1 CORE	There are written policies and procedures for the Clinical Services which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated. There is a mechanism for and evidence of a periodic review at least once in every three years. **EVIDENCE OF COMPLIANCE** 1. Documented policies and procedures for the service. — 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	NA			NA	
9.3.1.2	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved. Cross departmental collaboration is practised in developing relevant policies and procedures where applicable. **EVIDENCE OF COMPLIANCE** 1. Minutes of committee meetings on development and revision on policies and procedures. — NA 2. Minutes of meeting with evidence of cross reference with other departments — NA 3. Documented cross departmental policies — NA	NA			NA	
9.3.1.3 CORE	The policies and procedures documentation shall address at least the following topics and any others required by relevant standards and laws:	NA			NA	

	a) description of the organisational structure of the Clinical Services; b) clinical practice guidelines; c) clinical documentation includes pain as the 5th vital sign where appropriate; d) handover communication; e) drug prescription, dispensing and administration; f) blood transfusion; g) continuing of care including regular review of patient, review of investigation results, discharge [planned or At Own Risk (AOR)], referrals and escort as necessary; h) pain management; i) management of patients under police custody/prisoner; j) management of cases with an infectious disease including notification of notifiable diseases. k) the responsibilities of the staff including medical practitioners in relation to internal and external disasters are documented, and known to the staff (contingency plan); l) incident reports shall be compiled, investigated, discussed, and recorded and action plans implemented; m) end of life care; n) management of a death. EVIDENCE OF COMPLIANCE 1. Documented policies and procedures that address but not limited to (a) to (n). — NA					
9.3.1.4	Current policies and procedures are communicated to all staff. EVIDENCE OF COMPLIANCE 1. Training and briefing on the current policies and procedures/Minutes of meetings — NA 2. Circulation list and acknowledgement — NA	NA			NA	
9.3.1.5 CORE	There is evidence of compliance with policies and procedures. EVIDENCE OF COMPLIANCE 1. Compliance with policies and procedures through: a) interview of staff on practices; — NA b) verify with observation on practices; — NA c) results of audit on practices; — NA	NA			NA	

	d)	practices in line with established policies and procedures.	NA				
9.3.1.6	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 policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.	NA					
9.3.1.7	The services shall operate on a 24-hour basis providing a level of care appropriate to the activities of the patients in the Facility.			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 9.4
FACILITIES AND EQUIPMENT

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

CRITERION NO.	CRITERIA FOR COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
9.4.1.1	There are adequate and appropriate facilities and equipment with proper utilisation of space to enable staff to carry out their professional, teaching and administrative functions.		NA			NA	
	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				
9.4.1.2	Existing facilities shall take cognisance of the safety of staff 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 Clinical Services, e.g. emergency trolley, functioning patient call bell, etc.	NA				
	3.	Equipment should have scheduled planned preventive maintenance (PPM).	NA				
9.4.1.3	Suitable and adequate forms of communication and intercommunication systems and equipment are provided to enable clinical staff to communicate among themselves and with the other members of the healthcare team.		NA			NA	
	EVIDENCE OF COMPLIANCE						

	1.	Appropriate telecommunication modalities available for daily operation and during emergencies.	NA				

STANDARD 9.4.2

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
9.4.2.1	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					
9.4.2.2 CORE	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 (adults and children), suction machine, electrocardiogram (ECG) machine, infusion or syringe pump, vital sign monitor, etc.	NA					
	2.	Scheduled checking of items in emergency trolley	NA					
9.4.2.3	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					
9.4.2.4 CORE	There is evidence that the facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.			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				
9.4.2.5	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	User training records	NA				
	2.	Planned Replacement Programme where applicable	NA				
	3.	Complaint records	NA				
	4.	Asset inventory	NA				
9.4.2.6	Equipment is upgraded (based on evidence) from time to time so as to keep pace with advancement in operative and diagnostic techniques and technology.			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 9.4.3

FACILITIES FOR CLINICAL OUTPATIENT SERVICES Where visiting specialists or outpatient services are provided, there are adequate outpatient clinics to enable the provision of safe and effective patient care; and patient privacy and confidentiality are assured.

CRITERION NO.	CRITERIA FOR COMPLIANCE			SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
9.4.3.1	The Visiting Specialist or Outpatient Services shall have the following features: a) the organisation and management of the clinics are planned so as to ensure prompt attention to patients, minimal waiting time, and avoidance of unnecessary visits by the patients; b) record keeping shall be efficient; c) an appointment or queuing system is used to manage patient consultations; d) the clinic is easily accessible including for non-ambulant patients and is easily identified through adequate signage; e) the clinic is located close to other facilities, e.g. radiology, laboratories and pharmacy; f) adequate provision is made for patient comfort.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	The Visiting Specialist or Outpatient Services address (a) to (f) with evidence of but not limited to the following:						
	a)	list of services available and offered to patients;	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					

TOPIC 9.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 9.5.1
The Head of Clinical Services shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Clinical Services. The Head of Clinical Services shall ensure compliance to monitoring of specific performance indicators.

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

9.5.1.3	The Head of Clinical Services shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility. Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence." EVIDENCE OF COMPLIANCE 1. System for incident reporting is in place, which include: a) Training of staff — 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	NA			NA	
9.5.1.4 CORE	The staff including medical practitioners provide an appropriate peer group structure for performing the safety and performance improvement activities to accomplish clinical care evaluation. a) The medical practitioners undertake clinical reviews of all risk assessments, incident reports, audits and safety and performance improvement activities: i) as a single committee for all safety and performance improvement activities; ii) in a variety of purpose-specific committees, such as mortality and morbidity, blood transfusion and infection control. b) Whatever structure is utilised, provision is made for review and analysis of the clinical work of the service. c) Clinical service to provide input periodically to the Governing Body on the safety and performance improvement activities." EVIDENCE OF COMPLIANCE 1. Performance improvement activities — NA 2. Minutes of meetings — NA	NA			NA	

	3.	Relevant reports and documents, e.g. clinical audit reports, incident reports, mortality and morbidity review reports, etc	NA				
9.5.1.5 CORE	There is tracking and trending of specific performance indicators not limited to but at least two (2) of the following: a) number of mortality/morbidity audits/meetings being conducted in the department with documentation of cases discussed b) percentage of unplanned re-admission within 72 hours of discharge c) case fatality rate for two diseases (Facility to decide based on local disease prevalence) d) notification of infectious disease within stipulated period of time			NA			NA	
	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				
9.5.1.6	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/unit/committee meetings	NA				
9.5.1.7	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 indicator activities.	NA				
	2.	Policy statement on anonymity on patients and providers involved in performance improvement activities.	NA				

TOPIC 9.6
SPECIAL REQUIREMENTS

STANDARD 9.6.1
CONTINUITY OF CARE There shall be bi-directional line of care involving specialist and non specialist facility where appropriate level of care and optimum care to the patient is provided.

CRITERION NO.	CRITERIA FOR COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
9.6.1.1	Where the Facility's infrastructure or clinical response/level of care is does not commensurate with the patient's level of care required, arrangements shall be made for transfer to another facility or appropriate treatment centre.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Documented policies and procedures are established to govern the arrangement of different categories of patient transfer	NA				
	2.	Referral letter is available.	NA				
	3.	Contents in the referral letter are appropriately written and includes acceptance of the patient by the referred facility, name of receiving person	NA				
	4.	Ambulance transfer and in-transit records	NA				

STANDARD 9.6.2

WHO GLOBAL SURGERY INITIATIVE The WHO Global Surgery Initiative is organised to provide safe and efficient care for patients. The WHO Global Surgery Initiative is coordinated with other departments and services of the Facility. The service could also include patients treated and managed for medical conditions, diagnostic and interventional procedures.

CRITERION NO.	CRITERIA FOR COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
9.6.2.1	The Governing Body shall ensure that WHO Global Surgery Initiative is organised in such a way as to: a) facilitate the provision of surgical services to patients in the Facility in a safe, efficient, effective, and caring manner and with due regard for the needs, dignity and privacy of patients and confidentiality of their personal information; b) assure continuity of care; c) address the professional needs of the medical practitioners; d) ensure that the medical practitioners are involved in the formulation of policies and procedures concerning patient care appropriate to the scope of services of the Facility.		NA			NA	
	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 Advisory Committee /Medical Staff Committee and ward meetings.	NA				
	5.	Minutes of meetings	NA				
	6.	Proper and adequate equipment according to current standards.	NA				

SERVICE SUMMARY	
-	
OVERALL RATING :	NA
OVERALL RISK :	-