SERVICE STANDARD 09L : CLINICAL SERVICES – DENTAL SERVICES

PREAMBLE
Dental Services encompass the following specialties:
i. Oral & Maxillofacial Surgery
ii. Oral Pathology/ Oral Medicine
iii. Paediatric Dentistry
iv. Forensic Odontology
v. Special Care Dentistry

Dental Services play an integral role in delivering appropriate care and reducing unwarranted adverse events, as they meet the community's expectations regardless of where they are treated in the Facility. The Dental Services shall be organised, directed and coordinated with other services in the Facility to provide a high standard of inpatient and outpatient care to the community and cover the following:
a) appropriateness of clinical care;
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 Dental Services also conduct teaching and training, research and audit activities where applicable.

TOPIC 9L.1

ORGANISATION AND MANAGEMENT

STANDARD 9L.1.1

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

Comprehensive, holistic patient care is only possible when a range of services are both available and accessible, and all patients are able to obtain timely care and appropriate advice.

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
9L.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Dental Services are clearly documented and	NA			NA	

	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. **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 Dental 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					
9L.1.1.2 CORE	There is an organisation chart which: a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head of Dental Services, consultants, dental practitioners and staff of the Dental Services; b) reflects the relevant surgical subspecialties services/units; c) is accessible to all staff and clients; d) is revised when there is a major change in any of the following: i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns. **EVIDENCE OF COMPLIANCE** 1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head of Dental Services, relevant surgical subspecialties services/units, consultants, dental practitioners and staff of the Dental 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	NA			NA	

<table>
<tr>
<td>9L.1.1.3</td>
<td>The Governing Body shall ensure that Dental Services are organised in such a way as to:
a) facilitate the provision of Dental Services to patients in the Facility in a safe, efficient, effective, and caring manner and with due regard for the needs, dignity and privacy of patients and confidentiality of their personal information;
b) assure continuity of care;
c) address the professional needs of the dental practitioners;
d) ensure that the dental practitioners are involved in the formulation of policies and procedures concerning patient care appropriate to the scope of services of the Facility.

<table>
<tr><th colspan="3">EVIDENCE OF COMPLIANCE</th></tr>
<tr><td>1.</td><td>Departmental/Service operational policies that address</td><td>NA</td></tr>
<tr><td>2.</td><td>Medical Staff By-Laws</td><td>NA</td></tr>
<tr><td>3.</td><td>Evidence of involvement of dental practitioners in the formulation of policies and procedures concerning patient care</td><td>NA</td></tr>
<tr><td>4.</td><td>Involvement of Head of the Service in the Medical and Dental Advisory Committee/Medical Advisory Committee and ward meetings.</td><td>NA</td></tr>
<tr><td>5.</td><td>Minutes of meetings</td><td>NA</td></tr>
<tr><td>6.</td><td>Proper and adequate equipment according to current standards.</td><td>NA</td></tr>
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<td>NA</td><td></td><td></td><td>NA</td><td></td>
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<tr>
<td>9L.1.1.4</td>
<td>There is a mechanism to ensure effective interaction between the Dental Services and the Governing Body on all clinical aspects of healthcare and other relevant matters in the Facility. This mechanism is defined in the policies of the Governing Body and is accomplished through:
a) the appointment of a dental practitioner as the Head of Dental Services delineating his/her authority, responsibilities and accountabilities in a written document according to the relevant Acts to manage and control the Dental Services;
b) Medical and Dental Advisory Committee (MDAC) to advise the Governing Body on issues related to clinical governance, i.e. in planning, coordinating, implementation, control and to improve activities relating to Dental Services.

<table>
<tr><th colspan="3">EVIDENCE OF COMPLIANCE</th></tr>
<tr><td>1.</td><td>Letter of appointment/assignment and delineation of duties and responsibilities of the Head of the Service.</td><td>NA</td></tr>
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<td>NA</td><td></td><td></td><td>NA</td><td></td>
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	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				
9L.1.1.5 CORE	The Head of Dental Services has: a) representation of the Service in committees and subcommittees where relevant; b) representation of the Service in clinical staff liaison meetings; 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	NA				
	2.	Minutes of meetings of committees	NA				
	3.	Minutes of meeting of Senior Management Team.	NA				
9L.1.1.6	The assessment, planning, direction, evaluation and continuity of clinical care are the responsibility of dental practitioners managing individual patients, thus ensuring clinical independence.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Medical Staff By-Laws; clause indicate clinical care responsibility of dental 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 dental practitioner.	NA				
9L.1.1.7	The Head of Dental Services shall be involved for the following aspects of management of the services: 1. the preparation of budget and ensuring that expenditure remains within the budget allocated; 2. human resource management and development; 3. development of policies and procedures and ensuring compliance to them; 4. facility and equipment management; 5. 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 Dental Services 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				
9L.1.1.8	Regular staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Dental Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.			NA			NA	
	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. (recommended a minimum of 4 meetings in a year)	NA				
	4.	Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).	NA				
9L.1.1.9	Where there are dental practitioners in training, there is evidence that: a) their responsibilities for patient care are documented; b) their training needs are identified; c) appropriate supervision and training are given to the dental practitioners concerned.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Structured training programmes for dental practitioners are in place.	NA				
	2.	Training timetable, continuing medical education and attendances list	NA				
	3.	Assessment reports	NA				
	4.	Log books	NA				
9L.1.1.10	Appropriate statistics and records shall be maintained in relation to the provision of Dental Services and used for managing the services and patient care 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 records;	NA				
	f)	data on performance improvement activities, including performance indicators.	NA				
	2.	Clinical records should:					
	a)	Be easily retrievable	NA				
	b)	Include x-ray, results of investigation and study models where appropriate	NA				
	c)	Include detailed notes of treatment	NA				
	d)	Be signed, named and dated	NA				
	e)	Include treatment declined or non-compliance	NA				
	f)	Include a copy of all referral letters	NA				
	g)	Pre-procedural preparation by the practitioner administering the sedation	NA				
	h)	Pre-operative instructions – refer to Appendix 1 of Protocols for Day Care Anaesthesia	NA				
	i)	Intra-procedural monitoring – efficient record keeping, ensuring comprehensive and accurate information is recorded throughout the procedure until patient is fit for discharge.	NA				
	j)	Post-operative instructions – refer to Appendix 2 of Protocols for Day Care Anaesthesia	NA				
	3.	Where necessary the patient has a written treatment plan, which has been discussed and written consent given.	NA				
9L.1.1.11	Legal Requirements The clinical practice conforms to relevant statutory regulations. Current Acts and Guidelines are available and accessible to all staff.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	There is evidence of compliance to the guidelines issued by the regulatory body.	NA				
	2.	There is a clear delineation of authority.	NA				

	3.	The following documents are available and complied with;						
	a)	Infection Control Guidelines	NA					
	b)	Position Statement on the Use of Dental Amalgam	NA					
	c)	Guidelines on Radiation Safety in Dentistry (where applicable)	NA					
	d)	Guidelines and Provisions for Public Information	NA					
	e)	Guidelines for Oral Healthcare Practitioners Infected with Blood-borne Viruses	NA					
	f)	Private Healthcare Facilities and Services Act (PHFSA) 1998	NA					
	g)	Guidelines for Dental Record Keeping and Dental Charting	NA					
	4.	Organisation chart with line of authority and responsibilities	NA					

TOPIC 9L.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD 9L.2.1
CREDENTIALING AND PRIVILEGING
The Dental Services shall be directed by a qualified and competent dental practitioner, and staffed by suitably qualified and competent clinical staff to achieve the goals and objectives of the Dental Services.

Appropriate qualification/training is a prerequisite for the delivery of quality patient care. The practice demonstrates support for education and training of staff in order to provide safe and quality patient care.

<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>9L.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 Dental Council, Dental Specialist Register;
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), Dental Specialist Register certificate and privileging certificate. — NA</td><td>NA</td><td></td><td></td><td>NA</td><td></td></tr>
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	4.	Recommendations from peer/referee	NA				
	5.	Availability of the list of procedures requiring credentialing and privileging.	NA				
	6.	Availability of list of procedures to include core procedures specific to the disciplines performed by Dental Officers; competency records/log books. Credentialing and privileging must be given more weightage – either comply or non-compliance	NA				
9L.2.1.2 CORE	Documented evidence of privileges conferred by the Governing Body is available and accessible to relevant staff at point of care.			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				
9L.2.1.3 CORE	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; accessibility of the list be made available at point of care	NA				
	b)	operating list;	NA				
	c)	operating notes/clinical notes.	NA				
9L.2.1.4	The practice has a process for accepting patients for treatment. Urgent cases should be addressed as a priority.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Front desk staff able to identify urgent / priority cases	NA				
	2.	List of conditions defined as urgent is available (the clinic to define based on the services offered).	NA				
9L.2.1.5	There is evidence of adequate information given to the patients.			NA			NA	
	EVIDENCE OF COMPLIANCE							

	1.	Adequate information about patient's dental condition is given					
	a)	Information on procedure, possible complication, cost and duration of treatment is given.	NA				
	b)	Appropriate written consent should be taken.	NA				
	2.	A dental report is provided to the patient upon request and payment of fees.	NA				
	3.	The patient is given the opportunity to have a second opinion pertaining to patient's dental condition / treatment.	NA				
9L.2.1.6	Care provided is respectful of the patient's need for privacy during clinical consultation, examination and procedures. EVIDENCE OF COMPLIANCE			NA			NA	
	1.	There is evidence that the patient's needs for privacy during examinations and treatment is respected.	NA				
9L.2.1.7	The Dental Practitioner shall maintain a strictly professional relationship with all patients. EVIDENCE OF COMPLIANCE			NA			NA	
	1.	Code of Professional Conduct is observed.	NA				
	2.	A chaperon should be present at all times.	NA				
9L.2.1.8	There are written and dated specific job descriptions for all categories of staff that include: a) qualification, training, experience and certification required for the position; b) lines of authority; c) accountability, functions, and responsibilities; d) reviewed when required and when there is a major change in any of the following: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; 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
5.	The job description is acknowledged by the staff and signed by the Head of Service and dated.	NA

STANDARD 9L.2.2

STAFF TRAINING, EDUCATION, APPRAISAL AND RESEARCH

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

Appropriate qualification/training is a prerequisite for the delivery of quality patient care. The practice demonstrates support for education and training of staff in order to provide safe and quality patient care.

CRITERION NO.	CRITERIA FOR COMPLIANCE			SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
9L.2.2.1	There are continuing education activities for staff including dental practitioners to pursue professional interests and to prepare for current and future changes in practice.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	There is appropriate induction training which should include:						
	a)	Infection control procedures	NA					
	b)	Waste disposal	NA					
	c)	Radiation safety (where applicable)	NA					
	d)	Handling of amalgam (where applicable)	NA					
	2.	-						
	a)	Evidence of in-house training, e.g. Continuing Professional Development (CPD)	NA					
	b)	There is support for training, self-improvement and professional development.	NA					
	3.	Training calendar includes in-house/external courses/ workshop/conferences	NA					
	4.	Contents of training programme	NA					
	5.	Training records on continuing education activities are kept and maintained for each staff including training in life support.	NA					
	6.	Certificate of attendance/degree/post basic training	NA					
9L.2.2.2	The educational needs of staff and the Facility, as evidenced by the results of healthcare evaluation such as incident reports, performance improvement studies and complaints, are taken into consideration when the content and structure of educational activities are planned.			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				
9L.2.2.3	In a Facility where undergraduate dental, nursing and allied health training programmes are conducted, the Facility shall ensure that there are sufficient skilled trained staff to provide clinical supervision of students.		NA			NA	
	EVIDENCE OF COMPLIANCE					
	1.	Sufficient skilled trained staff to provide clinical supervision as per terms of Memorandum of Understanding.	NA				
9L.2.2.4	There is evidence of training needs assessment and staff development plan which provides the knowledge and skills required for staff to maintain competency 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				
9L.2.2.5	Staff including dental practitioners receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.		NA			NA	
	EVIDENCE OF COMPLIANCE					
	1.	Performance appraisal for staff including dental practitioner is completed upon probationary period and as an annual exercise.	NA				
9L.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, etc.	NA				

STANDARD 9L.2.3

STAFFING LEVEL AND STAFF COMPETENCY
The Head and staff of the Dental Services including dental 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
9L.2.3.1	Deployment of all service providers for Dental Services takes the following factors into consideration: a) the number of persons deployed is proportional to 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 dental practitioner to be available on call. EVIDENCE OF COMPLIANCE 1. Documentation and planning on deployment of staff that includes but not limited to (a) to (e) with evidence 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	NA			NA	
9L.2.3.2	Appropriate and adequate staffing is available. EVIDENCE OF COMPLIANCE 1. Valid Practising Certificate. NA	NA			NA	

	2.	Number of support staff commensurate with number of practitioners.					
	a)	A ratio of at least 1 operator: 1 clinical support staff member.	NA				
	b)	A ratio of 1 clinical support staff: 1 dental chair.	NA				
	c)	At least 1 administrative staff member.	NA				
	3.	Job descriptions for staff are available. Different categories of staff are identifiable.	NA				
	4.	Staff employment complies with labour laws	NA				
9L.2.3.3	Adequate information as to the practice hours is available.			NA			NA
	EVIDENCE OF COMPLIANCE						
	1.	Operating hours displayed to be seen from outside the clinic	NA				
	2.	Information is available to patients to access care out of normal surgery hours.	NA				
9L.2.3.4	Comprehensive and clear information of the services available which will enable the patients to choose the practice that best meets the patient needs.			NA			NA
	EVIDENCE OF COMPLIANCE						
	1.	List of services displayed in clinic.	NA				
	2.	Patient information on services / treatments offered.	NA				
9L.2.3.5	Treatment/services is fair and accessible to all patients.			NA			NA
	EVIDENCE OF COMPLIANCE						
	1.	The practice does not discriminate on the grounds of:					
	a)	Race, gender, social class, age, religion, sexual orientation or appearance	NA				
	b)	Disability or medical condition	NA				

STANDARD 9L.2.4

STAFF ORIENTATION

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

<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>9L.2.4.1</td><td>There is a structured orientation programme for all newly appointed staff to the Dental Services including dental 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 Dental 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 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 Dental 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 at least 2 languages;
n) educate on management of clinical alarm system cross reference to nursing policy;

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

TOPIC 9L.3
POLICIES AND PROCEDURES

STANDARD 9L.3.1

DEVELOPMENT, DERIVATION AND DOCUMENTATION
There are written and dated policies and procedures for all activities of the Dental Services. These policies and procedures reflect current standards of medical practice, relevant regulations, statutory requirements, and the purposes of the services. These policies and procedures, terms of reference, by-laws, rules or regulations, state how the clinical staff including dental 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
9L.3.1.1 CORE	There are written policies and procedures for the Dental Services which are consistent with the overall policies of the Facility, regulatory requirements 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	
9L.3.1.2	Policies and procedures are developed by a committee in collaboration with staff, dental 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**	NA			NA	

	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						
9L.3.1.3 CORE	The policies and procedures documentation shall address at least the following topics and any others as required by relevant standards and laws: a) description of the organisational structure of the Dental Services; b) clinical practice guidelines (where appropriate).; a. Management of Hypodontia b. Management of Chronic Periodontitis c. Management of Periodontal Abscess d. Management of Severe Early Childhood Caries e. Management of Avulsed Permanent Anterior Teeth in Children f. Management of Ameloblastoma of the Jaw g. Antibiotic Prophylaxis against Wound Infection for Oral Surgical Procedures h. Management of Unerupted Maxillary Incisor i. Management of Unilateral Condylar Fracture of the Mandible j. Management of Unerupted and Impacted Third Molar Tooth k. Management of the Palatally Ectopic Canine l. Management of Anterior Crossbite in the Mixed Dentition c) clinical documentation includes pain as the 5th vital sign where appropriate; d) handover communication in timely manner; e) drug prescription, dispensing and administration; f) blood transfusion; g) continuing of care including regular review of patient, review of investigation results, discharge (planned or At Own Risk), referrals and escort as necessary; h) pain management; i) management of patients under police custody/prisoner; j) management of cases with an infectious disease including notification of notifiable diseases; k) the responsibilities of the staff including dental practitioners in relation to internal and external disasters are documented, and known to the staff (contingency plan); n) incident reports shall be compiled, investigated, discussed and recorded and action plans implemented; l) safe use or lasers devices cross reference to standard 3 m) management of high risk patients or high risk services – emergency, comatose, immunosuppressive, on life support, on dialysis, with communicable disease, in restraints, receiving chemotherapy, vulnerable patients and palliative care (nursing policy – standard 4)	NA			NA	

	n) register of implantable medical devices registered under Medical Device Acts. o) Compliance to SOPs for the use of loan equipment EVIDENCE OF COMPLIANCE 1. Documented policies and procedures that address but not limited to items (a) to (n). — NA						
9L.3.1.4	Information on fees to be charged is made available to the patient. EVIDENCE OF COMPLIANCE 1. Fee schedule is available and accessible. — NA 2. Patient is informed of the details of fees that will be charged, prior to commencement of treatment. — NA 3. A receipt is given for every payment and an itemised bill is given to the patient upon request. — NA 4. Adherence to code of conduct — NA	NA			NA		
9L.3.1.5	Patient assessment shall be appropriate, comprehensive and documented EVIDENCE OF COMPLIANCE 1. Appropriate assessment is conducted to support care of the patient. — NA 2. Appropriate reassessment of patient is carried out to ensure continuity of care. — NA 3. Evidence that service delivery is planned and monitored. — NA 4. Patients are reassessed at appropriate intervals — NA 5. Mechanism for incident reporting shall be established, documented and acted upon to prevent recurrences. — NA 6. Evidence that service delivery is planned and monitored. — NA	NA			NA		
9L.3.1.6	Patient health records contain sufficient information to identify the patient OR patient undergoing for treatment under sedation and to document reasons for visit, assessment, management, progress and outcome. EVIDENCE OF COMPLIANCE 1. The Registered Dental Practitioner maintains a system of creating and updating Dental information on every patient — NA	NA			NA		

	2.	Each patient has an individual health record containing all relevant clinical information.	NA				
	3.	There is efficient record keeping, ensuring comprehensive and accurate information is recorded.	NA				
	4.	There is a daily record of patients attending the clinic.	NA				
	5.	Every patient has an individual record.	NA				
	6.	An initial examination should include but is not limited to: • medical history • full dental charting • risk habits (including tobacco use) • periodontal status • soft tissue examination • appliances used	NA				
9L.3.1.7	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				
9L.3.1.8 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 including current CPGs	NA				
9L.3.1.9	Copies of current 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				

9L.3.1.10	The services shall operate on a 24-hour basis providing a level of care appropriate to the activities of the patients in the Facility. 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		NA			NA	

TOPIC 9L.4

FACILITIES AND EQUIPMENT

STANDARD 9L.4.1

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

CRITERION NO.	CRITERIA FOR COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
9L.4.1.1	There are adequate and appropriate facilities and equipment with proper utilisation of space to enable staff to carry out their professional, teaching and administrative functions.		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 trolley, hand washing facilities etc)	NA				
	4.	Easy access and clear exit routes	NA				
	5.	Absence of overcrowding	NA				
9L.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. consultation room, wards, dental surgery rooms, dental x-ray room /area, dirty and clean utility rooms, access, lighting, signage, etc address the safety aspects of patients and staff.	NA				
	2.	Adequate equipment and supplies for Dental Services, e.g. emergency trolley, functioning patient call bell, etc.	NA				
	3.	Equipment should have scheduled planned preventive maintenance (PPM).	NA				

9L.4.1.3	The facility designs and implements a coordinated programme to reduce the risks of facility acquired infections in patients and staff. Responsibility for infection control is undertaken by the Person In-Charge (PIC). EVIDENCE OF COMPLIANCE 1. Infection control protocols are available and compliance is in place — NA 2. Equipment and instrument a) Sufficient autoclaves, at least 2 available (to allow efficient sterilisation procedures to be followed and to minimise risk of service disruption should one fail). — NA b) All instruments are sterilised. — NA c) Autoclaved instruments are stored in sealed pouches with packing date and expiry date recorded on the pouch. — NA d) All hand-pieces are sterilised between patients — NA 3. All sharps are disposed directly into clinical waste sharps bin. — NA 4. All clinical staff wear personal protective equipment — NA 5. Staff education on Infection Control procedures. — NA 6. Records of refresher courses are available. — NA	NA			NA	
9L.4.1.4	The facility practices appropriate waste management. There shall be a waste and environmental management policy that supports safe practice. EVIDENCE OF COMPLIANCE 1. Clinical waste management protocol adheres to relevant regulations and guidelines. — NA 2. General waste management protocol available. — NA 3. Chemical waste management protocol adheres to where appropriate — NA 4. Controls are implemented to cover identification, handling, separation of clinical, chemical, general waste and scheduled waste. — NA 5. Waste is managed in accordance with relevant legislation, codes of practice, standards and guidelines. — NA 6. Instruments are cleaned of waste amalgam before sterilizing (where applicable). — NA 7. Waste amalgam is collected from amalgam trap in the spittoon and separator at suction unit. — NA	NA			NA	

	8.	Extracted teeth with amalgam restorations disposed as scheduled waste	NA				
9L.4.1.5	The facility provides a safe and healthy environment.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Occupational safety and health measures:						
	a)	All staff comply with the protocol for management of spillage of blood and other body fluids.	NA					
	b)	Clinical staff immunised against hepatitis	NA					
	c)	Hazardous materials are labelled.	NA					
	2.	Mercury Hygiene Practice (where applicable)						
	a)	Only encapsulated amalgam used	NA					
	b)	Closed non-fragile container used for storage of waste amalgam	NA					
	c)	Waste amalgam stored dry	NA					
	3.	Radiation Safety (where applicable)						
	a)	Warning sign / light during x-ray operation	NA					
	b)	Protective equipment (lead apron with thyroid shield for conventional radiography) is used and in good condition	NA					
	c)	Protective equipment for operator is available and in good condition	NA					
	d)	Precautionary signages for antenatal mother displayed	NA					
	e)	Reports on radiographs are included in clinical notes.	NA					
	f)	Valid license for X-ray equipment	NA					
	g)	A quality assurance programme is in place. (e.g. Film rejects rate)	NA					
	4.	Floor plan and signages						
	a)	Floor plan with safety equipment and emergency exit indicated.	NA					
	b)	relevant safety signages displayed	NA					
	5.	Dental Laboratory (where applicable)						
	a)	Gas tank placed in a designated safe area.	NA					
	b)	Machines used for polishing prosthesis/ appliance have a vacuum system and safety protector	NA					
	c)	Material and equipment for disinfection process available.	NA					
	d)	Fume cupboard is available where acrylic work is carried out.	NA					

	e)	Laboratory staff wear appropriate personal protective equipment during laboratory work	NA				
	6.	Disaster management system in place.	NA				
9L.4.1.6	Suitable and adequate forms of communication and intercommunication systems and equipment are provided to enable clinical staff to communicate among themselves and with the other members of the healthcare team.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Appropriate telecommunication modalities available for daily operation and during emergencies.	NA				

STANDARD 9L.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
9L.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				
9L.4.2.2	The practice conforms to all structures and physical requirements appropriate to the level of services under the relevant statutory regulations.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	There is valid registration of the practice with the relevant authority.	NA				
	2.	The physical structure of the clinic shall comply with all relevant regulatory requirements.	NA				
	3.	Dental X-ray Room/ Area					
	a)	Physical structure compliant	NA				
9L.4.2.3	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, etc.	NA				
	2.	Scheduled checking of items in emergency trolley	NA				
9L.4.2.4	All equipment for the provision of the level of services shall be adequate, appropriate and well maintained.		NA			NA	

	EVIDENCE OF COMPLIANCE						
	1.	There is evidence of compliance where appropriate to:					
	a)	Certification	NA				
	b)	Scheduled maintenance	NA				
	c)	Calibration	NA				
	2.	Planned preventive maintenance.					
	a)	Evidence of Programme for maintenance and calibration of equipment and facility available [OSHA, Sec 15(2)(a)] Report/test/QA certificate available for:					
	i)	imaging equipment	NA				
	ii)	autoclave	NA				
	iii)	compressor	NA				
	3.	Where specialised equipment is used:					
	a)	ensure appropriately qualified staff operates such equipment.	NA				
	b)	when laser equipment is used, warning sign is displayed outside the operating room.	NA				
	c)	when inhalation sedation is used, scavenging system is available.	NA				
9L.4.2.5	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				
9L.4.2.6 CORE	There is evidence that the facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.			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				
9L.4.2.7	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.			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, example:						
	a)	imaging equipment	NA					
	b)	laser equipment	NA					
	c)	autoclaves	NA					
	d)	etc as appropriate	NA					
9L.4.2.8	Equipment is upgraded (based on evidence) from time to time so as to keep pace with advancement in operative and diagnostic techniques and technology.			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 9L.4.3

FACILITIES FOR SURGICAL RELATED OUTPATIENT SERVICES

Where specialist outpatient services are provided, there are adequate outpatient clinics to enable the provision of safe and effective patient care; and patient privacy and confidentiality are assured.

CRITERION NO.	CRITERIA FOR COMPLIANCE			SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
9L.4.3.1	There is an appointment system available in the practice which is designed to minimise waiting time			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	A patient appointment system is practiced based on treatment needs	NA					
	2.	There is an appointment system.	NA					
	3.	The duration of appointments is based on treatment procedures.	NA					

TOPIC 9L.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

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

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
9L.5.1.1 CORE	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Dental Services. The process includes: a) Planned activities b) Data collection - POMR reporting be made mandatory so that data can be first collected before analysis be made c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement 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					
9L.5.1.2	The Head of Dental 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				
9L.5.1.3	The Head of Dental Services shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility. Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.		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				
9L.5.1.4 CORE	The staff including dental practitioners provide an appropriate peer group structure for performing the safety and performance improvement activities to accomplish clinical care evaluation. a) The dental 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. 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.		NA			NA	

	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				
9L.5.1.5 CORE	The quality improvement activities include evaluation of clinical and non-clinical services.			NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Adequate records are maintained about quality improvement activities.	NA				
	2.	An appropriate complaint mechanism is available	NA				
	3.	There is an identified member of the staff to lead in quality improvement activities in the practice.	NA				
	4.	Evidence of quality improvement initiatives.	NA				
	5.	There shall be a formal method of feedback on the facility and services from the patient and staff (e.g. suggestion box).	NA				
	6.	Evidence that suggestions from feedback are considered and implemented where appropriate.	NA				
	7.	A grievance mechanism shall be in place	NA				
9L.5.1.6 CORE	There is tracking and trending of specific performance indicators not limited to but at least two (2) of the following: a) number of mortality/morbidity audits/meetings being conducted in the department with documentation of cases discussed b) percentage of unplanned re-admission within 72 hours of discharge c) unplanned return to operating theatre within the same hospital admission following surgery d) waiting time according to Client Charter e) completion of medical report within 14 days Specialty units in the Dental Services Specialty units in the Dental Services (e.g. OMF, Paeds Dentistry, OMOP, Special Care Dentistry, Forensic Odontology), shall monitor any other two (2) indicators to support its goals and objectives.			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				
9L.5.1.7	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				
9L.5.1.8	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of dental 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				

TOPIC 9L.6
SPECIAL REQUIREMENTS

SEDATION IN DENTAL PRACTICE

Sedation during dental procedures is no longer uncommon. When it is used judiciously, sedation can be a useful adjunct to many dental procedures.

When performed by non-anaesthesiologists, the level of sedation should be kept at mild to moderate. Deep sedation should be avoided unless an anaesthesiologist or a physician with expertise in airway management is present throughout the procedure.

STANDARD 9L.6.1
CLINICAL GOVERNANCE FOR SEDATION

CRITERION NO.	CRITERIA FOR COMPLIANCE			SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
9L.6.1.1	The clinical practice conforms to relevant recommendations and guidelines. Current documents are available and accessible to all staff.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	There is evidence of compliance to the guidelines issued by the regulatory body.	NA					
	2.	The following documents are available and complied with:						
	a)	Recommendations for Sedation and Analgesia by Non-Anaesthesiologists	NA					
	b)	Protocols for Day-care Anaesthesia	NA					

STANDARD 9L.6.2

HUMAN RESOURCE FOR SEDATION

Appropriate qualifications/training is a prerequisite for the delivery of quality patient care. The practice ensures that suitably qualified staff are employed for the level of services offered and demonstrates support for education and training of staff in order to provide safe and high quality patient care.

CRITERION NO.	CRITERIA FOR COMPLIANCE			SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
9L.6.2.1	Personnel with relevant training is available.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	The practitioner administrating oral or inhalation sedation must have appropriate training and be certified in Basic Life Support (BLS)	NA					
	2.	The practitioner administering intravenous sedation must have recognised training in intravenous sedation and be certified in Basic Life Support (BLS)	NA					
	3.	Proof of training in administration of oral or inhalation sedation	NA					
	4.	Valid BLS certificate	NA					
	5.	Proof of training in IV sedation	NA					

STANDARD 9L.6.3

POLICY FOR SEDATION
The aims of procedural sedation and/or analgesia are to enhance patient comfort whilst facilitating completion of the planned procedure.

CRITERION NO.	CRITERIA FOR COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
9L.6.3.1	The practice must declare their services regarding sedation.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Practice policies are available.	NA				
	2.	Documentation on practice policies regarding sedation and anaesthesia is available, and includes the following:					
	a)	Patient must be accompanied by a responsible adult.	NA				
	b)	The patient has to remain in the facility for at least 1 hour post-sedation	NA				
	3.	Patients received written pre and post-operative advice for surgical procedures and procedures carried out under conscious sedation	NA				

STANDARD 9L.6.4

FACILITIES FOR SEDATION WITH INTRAVENOUS (IV)

CRITERION NO.	CRITERIA FOR COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
9L.6.4.1	The practice conforms to all structures and physical requirements appropriate to the level of services under the relevant statutory regulations.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	There is valid registration of the practice with the relevant authority NA					
	2.	The physical structure of the clinic shall comply with all relevant regulatory requirements. NA					
	3.	Electrical source					
	a)	Sufficient and appropriately placed power outlets NA					
	b)	Power backup is available in case of disruption in electric supply NA					
	4.	Sedation room and/cum recovery bay The procedure must be performed in a room that is of adequate size, and is equipped to deal with a cardiopulmonary emergency. NA					
9L.6.4.2	All equipment for the provision of the level of services shall be adequate, appropriate and well maintained. a) Availability b) Planned preventive maintenance		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	The appropriate equipment is available in the facility, based on the level of sedation practised. NA					
	2.	The equipment may include the following:					
	a)	a pulse oximeter NA					
	b)	a sphygmomanometer or other blood pressure monitoring device NA					
	c)	a supply of oxygen and suitable devices for administration of oxygen to a spontaneously breathing patient. (compulsory for IV sedation) NA					

	d)	an Automatic External Defibrillator (AED) is available (compulsory for IV sedation)	NA				
	e)	ready access to an ECG	NA				
	f)	Availability of resuscitation trolley with appropriate drugs and equipment for cardiopulmonary resuscitation					
	i)	Instruments in the Resuscitation Trolley must include the following for IV and oral sedation:					
	•	Syringes and needles of various sizes	NA				
	•	Intravenous cannula of various sizes	NA				
	•	IV administration sets	NA				
	•	Oropharyngeal airways, nasopharyngeal airways of various sizes	NA				
	•	Laryngoscopes and blades of various sizes	NA				
	•	Endotracheal tubes of various sizes	NA				
	•	Self-inflating bags with face masks (e.g. Ambu bag)	NA				
	•	Oxygen supply and means of delivery via flowmeters	NA				
	•	Suction equipment	NA				
	•	Pulse oximeter, Non-invasive blood pressure monitor (NIBP), ECG	NA				
	•	Defibrillator	NA				
	ii)	The drugs in the Resuscitation Trolley must include the following for IV and oral sedation:					
	•	Adrenaline	NA				
	•	Atropine	NA				
	•	Frusemide	NA				
	•	Lignocaine	NA				
	•	Sodium Bicarbonate 8.4%	NA				
	•	Calcium chloride	NA				
	•	Nitroglycerine	NA				
	•	Naloxone	NA				
	•	Flumazenil	NA				
	•	Hydrocortisone	NA				
	g)	a means of summoning emergency assistance	NA				

	h)	Planned preventive maintenance Evidence of scheduled maintenance and calibration of equipment and appliances [OHSA, Sec 15(2)(a)]	NA					
	i)	Where specialised equipment is used:						
	i)	ensure appropriately qualified staff operate such equipment	NA					
	ii)	when inhalation sedation is used, a scavenging system is mandatory	NA					
	3.	There is evidence of compliance where appropriate to:						
	a)	Certification	NA					
	b)	Scheduled maintenance	NA					
	c)	Calibration	NA					

SERVICE SUMMARY	
-	
OVERALL RATING :	NA
OVERALL RISK :	-