SERVICE STANDARD 12B : AMBULATORY CARE SERVICES (OPHTHALMOLOGY SERVICES)

PREAMBLE

Ambulatory care is defined as scheduled procedures provided to patients who do not require hospital stay overnight. It is a process of care where suitable patients are managed with admission, treatment and discharge on the same day. Ambulatory care is done for diagnostic and therapeutic procedures which may require topical, local, regional, monitored anaesthetic care or general anaesthesia, with minimal or do not carry risk of post-operative complications but require a period of observation in the Ambulatory Care Centre. Ambulatory care services can be provided as hospital based or stand-alone centres.

There are guidelines to specify which patients can be treated, which procedures and under what form of anaesthesia/sedation can be performed as ambulatory care. The service could also include patients treated and managed in the day care for ophthalmological conditions, diagnostic and interventional procedures.

Ambulatory care centre performing any procedure for the stay of any one patient for a period of not more than 23 hours is provided and from which patients are either discharged in an ambulatory condition without requiring constant or continuous care or supervision and without danger to the continued well-being of the patient or transferred to a hospital. [Reference: Private Healthcare Facilities and Services Act 1998 (Act 586)]

TOPIC TOPIC 12B.1
ORGANISATION AND MANAGEMENT

STANDARD STANDARD 12B.1.1

The Ophthalmology Ambulatory Care Services are organised to provide safe and efficient care for ambulatory patients. The service includes patients treated and managed in the day care for ophthalmological conditions, diagnostic and interventional procedures.

CRITERION NO.	CRITERIA FOR COMPLIANCE			SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
12B.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Ophthalmology Ambulatory Care 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 Ophthalmology Ambulatory Care Services in line with the Facility/Centre's 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				
12B.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 the Ambulatory Care Services, consultants, medical practitioners and staff of the Ambulatory Care Services; b) to all staff and clients; c) includes off-site services if applicable; d) is revised when there is a major change in any one of the following: i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head of the Ambulatory Care Services, consultants, medical practitioners and staff of the Ambulatory Care 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				
12B.1.1.3	The Governing Body shall ensure that Ambulatory Care Services are organised in such a way as to: a) facilitate the provision of ambulatory care 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/Centre 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	NA				
	4.	Involvement of Head of the Service in the Medical Advisory Committee and service meetings.	NA				
	5.	Minutes of meetings	NA				
12B.1.1.4	The Ambulatory Care Services shall adopt a governing framework in accordance with statutory and other legal requirements.			NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	License to operate (Private Healthcare Facility)/Gazettement letters and supporting documents (Public Healthcare Facility)	NA				
	2.	Appointment of full time Person In Charge (PIC) in accordance with the Fourth Schedule in Private Healthcare Facilities and Services Act 1998 and Regulations 2006.	NA				
12B.1.1.5 CORE	The Person In Charge (PIC) of the Ambulatory Care Services (Ophthalmology Services)/Centre has : a) representation of the Service in relevant committees; b) heads clinical staff meetings; c) provides regular input on the operations of the Services to the Management Team.			NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Letter of appointment and delineation of duties and responsibilities of the Head of the Service/ Centre	NA				
	2.	Letter of appointment and Terms of Reference as member of the Medical Advisory Committee i.e. hospital based service	NA				
	3.	Minutes of meetings of Medical Advisory Committee/Management	NA				
	4.	Letter of appointment for representation in relevant committees, e.g., Operating Theatre Committee and minutes of meetings.	NA				
12B.1.1.6	Regular staff meetings are held between the Head of Service/Centre and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the			NA			NA	

	Ambulatory Care Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented. **EVIDENCE OF COMPLIANCE** 1. Minutes are accessible, disseminated and acknowledged by the staff. NA 2. Attendance list of members with adequate representatives of the service NA 3. Frequency of meetings as scheduled. NA 4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved). NA					
12B.1.1.7	The Head of the Ambulatory Care Services/Centre is involved in the planning, justification and management of the budget and resource utilisation of the services. **EVIDENCE OF COMPLIANCE** 1. Minutes of Facility-wide management meeting NA 2. Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service. NA 3. Approved budget and resources. NA	NA			NA	
12B.1.1.8	The Head of the Ambulatory Care Services/Centre is involved in the appointment and/OR assignment of staff. **EVIDENCE OF COMPLIANCE** 1. Records on staff interview (if applicable) NA 2. Appointment/assignment letter of Head of Service NA 3. Job description of Head of Service/Centre NA 4. Records on staff deployment NA 5. Duty roster NA	NA			NA	
12B.1.1.9	Ambulatory Care Services are provided appropriate to the Facility's scope of medical and surgical services. **EVIDENCE OF COMPLIANCE** 1. List of ambulatory care services provided NA 2. Patient registration records NA	NA			NA	

12B.1.1.10	Appropriate statistics and records shall be maintained in relation to the provision of Ambulatory Care Services and used for managing the services and patient care purposes. **EVIDENCE OF COMPLIANCE** 1. Records are available but not limited to the following: a) workload/census; NA b) annual report; NA c) accident/incident reports; NA d) staffing number and staff profile; NA e) staff training records; NA f) data on performance improvement activities, including performance indicators. NA	NA			NA	
12B.1.1.11	Appropriate records are maintained by the Ambulatory Care Services/Centre which are adequate for clinical, medicolegal, and evaluation purposes and include the following: a) a record of medical practitioners conferred the privileges of performing specific procedures is available and accessible to all staff b) a register of operations/procedures performed within the Ambulatory Care Services/Centre is maintained; c) a record of the procedure performed is filed in the patient's medical record; d) standard drug administration records are maintained and regulations relating to the control of drugs are followed; documented evidence of the counting of accountable items used in the procedures (including operating theatre) and a copy of this is included in the patient's medical record. **EVIDENCE OF COMPLIANCE** 1. Records maintained by Ambulatory Care Services include (a) to (e) NA 2. Privileges of clinical staff performing specific procedures is available at point of care. NA 3. Record of the procedure performed and documented in the patient’s medical record details the following: a) procedure performed; NA b) date and time; NA	NA			NA	

	c)	type of anaesthesia;	NA					
	d)	personnel involved in the procedure;	NA					
	e)	findings;	NA					
	f)	record of accountable items used in operating theatre;	NA					
	g)	the dressings applied and drainage systems inserted (where applicable);	NA					
	h)	postoperative orders;	NA					
	i)	discharge and follow up notes.	NA					

STANDARD STANDARD 12B.1.2

Where external services are used to assist in the operations of the Facility, these contracted or referral services shall meet the MSQH Standards of Accreditation.

<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>12B.1.2.1</td><td>There are written agreements on the appointment and provision of external services to the Facility, which include the following:

a) The services shall meet all patient and environmental safety standards contained in the MSQH Standards of Accreditation, regardless of where the activities occur, on-site and off-site.
b) There is documentation on the external aspects of the services which refer to:

i) specification of formal lines of communication and responsibility between the external source provider and the Facility;
ii) provision of services by personnel appropriately qualified to perform their duties;
iii) adequate pick-up and delivery arrangements;
iv) appropriate participation of the external service provider in committees of the Facility where applicable;
v) arrangements for after-hours and emergency services;
vi) quality control of the external services including involvement in safety and performance improvement activities of the Facility, as appropriate;
vii) procedures for identifying and rectifying problems in the delivery of the services;
viii) adequacy of facilities and equipment for the services being provided at both the Facility and the site of the external services;
ix) personnel provided by the external services who shall be bound by the rules and regulations applicable to the staff of the Facility.

EVIDENCE OF COMPLIANCE
1. Service contracts have appropriate terms and conditions as in (a) and (b) including:
a) date and duration of contract; — NA
b) system for quality control of outsourced services (visit to off-site services, recognised certification, etc); — NA
c) procedures for managing shortfall in service; — NA
d) Involvement in performance measurement of the relevant services provided to the Facility. — NA</td><td>NA</td><td></td><td></td><td>NA</td><td></td></tr>
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TOPIC TOPIC 12B.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD STANDARD 12B.2.1
The Ophthalmology Ambulatory Care Services shall be directed by a qualified and competent National Specialist Register (NSR) registered ophthalmologist and staffed by suitably qualified and competent clinical staff to achieve the goals and objectives of the services. Staff of the services have access to appropriate education programmes to maintain and improve their knowledge and skills.

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
12B.2.1.1	The Head and staff of the Ophthalmology Ambulatory Care Services/Centre shall be individuals qualified by education, training, experience and certification to commensurate the requirements of the various positions. The appointment of Head and staff of the Ophthalmology Ambulatory Care Services/Centre shall conform to the statutory requirements. EVIDENCE OF COMPLIANCE 1. Records on credentials of Head of Service and staff required to fill up the posts within the service (to match the complexity of the Facility and services) and certification/registration. — NA 2. Appointment/assignment letter — NA 3. Training and competency records — NA	NA			NA	
12B.2.1.2	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 (two years and when as needed) for which the privileges are to be granted is specified;	NA			NA	

	e) current registration with the local professional registration bodies, e.g. Malaysian Medical Council, National Specialist Register (NSR), Nursing Board, Medical Assistant Board, Malaysian Optical Council, Pharmacy Board; f) peer recommendations are taken into account when privileges are being considered; g) the recommendations of the relevant department and/or major professional services for privileges to be granted are taken into consideration. **EVIDENCE OF COMPLIANCE** 1. Documented policies and procedures are established to govern the credentialing and privileging processes which include items (a) to (g). — NA 2. Compliance with policy and criteria for credentialing and privileging — NA 3. Annual Practising Certificate (APC), National Specialist Register (NSR) certificates and privileging certificates. — NA 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 medical officers; competency records/log books. — NA					
12B.2.1.3	The authority, responsibilities and accountabilities of the Head of Ophthalmology Ambulatory Care Services/Centre are clearly delineated and documented. **EVIDENCE OF COMPLIANCE** 1. Appointment/assignment letter for Head of Service — NA 2. Description of duties and responsibilities — NA	NA			NA	
12B.2.1.4	Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the need of the services and commensurate with the number of ophthalmologists and patients. There shall be minimum one (1) nurse to four (4) patients at all times in pre-operative and recovery bay. There shall be minimum two (2) registered nurses in one (1) operating room, including at least one (1) post basic ophthalmology trained nurse in each operating room. The number of nurses shall be commensurate with the number of operating rooms.	NA			NA	

	EVIDENCE OF COMPLIANCE					
	1.	Number of staff and qualification should commensurate with workload.	NA			
	2.	Staffing pattern	NA			
	3.	Duty roster	NA			
	4.	Census and statistics	NA			
12B.2.1.5	There are written and dated specific job descriptions for all categories of staff that include: a) qualifications, training, experience and certification required for the position; b) lines of authority; c) accountability, functions and responsibilities; d) reviewed when required and when there is a major change in one 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			
12B.2.1.6 CORE	Clinical staff performs within the privileges conferred		NA			NA
	EVIDENCE OF COMPLIANCE					

	1.	Verification of procedures e.g. phacoemulsification, etc performed by individual at point of care within the awarded privileging rights with evidence of:					
	a)	list of procedures privileged;	NA				
	b)	clinical notes.	NA				
12B.2.1.7	Personnel records on training, staff development, leave and others are maintained for every staff. Note: *Staff personal record may be kept in Human Resource Department as per Facility policy*.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Staff personal records include:					
	a)	staff biodata;	NA				
	b)	qualification and experience;	NA				
	c)	evidence of current registration;	NA				
	d)	training record;	NA				
	e)	competency record and privileging;	NA				
	f)	leave record;	NA				
	g)	confidentiality agreement.	NA				
12B.2.1.8	There is a structured orientation programme for all newly appointed staff to the Ophthalmology Ambulatory Care Services/Centre 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 Ophthalmology Ambulatory Care Service/Centre; 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;			NA			NA	

	f) processes for resolving practice dilemmas; g) information about safety procedures; h) training in basic/advanced life support techniques; i) methods of obtaining appropriate resource materials; j) staff appraisal procedures for the Ophthalmology Ambulatory Care Services/Centre; k) education on WHO and Malaysian Patient Safety Goals (where applicable); l) education on Patient and Family Rights; m) education on MSQH Standards requirements. **EVIDENCE OF COMPLIANCE** 1. Policy requiring all new staff to attend a structured orientation programme. — NA 2. There is Ophthalmology Ambulatory Care Services/Centre orientation programme with relevant topics not limited to topics covered from (a) to (m). — NA 3. Attendance list — NA					
12B.2.1.9	There are continuing education activities for staff including medical practitioners to pursue professional interests and to prepare for current and future changes in practice. **EVIDENCE OF COMPLIANCE** 1. Training calendar includes in-house/external courses/ workshop/conferences — NA 2. Contents of training programme — NA 3. Training records on continuing education activities are kept and maintained for each staff including training in life support. — NA 4. Certificate of attendance/degree/post basic training — NA	NA			NA	
12B.2.1.10	There is evidence of training needs assessment (example based on incidents and accidents that had occurred, complaints, patients' feedback, etc) and staff	NA			NA	

	development plan which provides the knowledge and skills required for staff to maintain competency in their current positions and future advancement. **EVIDENCE OF COMPLIANCE** 1. Training needs assessment is carried out and gaps identified. — NA 2. A staff development plan based on training needs assessment is available. — NA 3. Training schedule/calendar is in place. — NA 4. Training module — NA					
12B.2.1.11	There are continuing education activities for staff including medical practitioners to pursue professional interests and to prepare for current and future changes in practice. **EVIDENCE OF COMPLIANCE** 1. Training calendar includes in-house/external courses/ workshop/conferences — NA 2. Contents of training programme — NA 3. Training records on continuing education activities are kept and maintained for each staff including training in life support. — NA 4. Certificate of attendance/degree/post basic training — NA	NA			NA	
12B.2.1.12	Medical practitioners (including consultants, specialists and medical officer) and staff receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility. **EVIDENCE OF COMPLIANCE** 1. Performance appraisal for medical practitioners (including consultants, specialists and medical officer) and staff is completed upon probationary period and as an annual exercise. — NA	NA			NA	

TOPIC TOPIC 12B.3
POLICIES AND PROCEDURES

STANDARD STANDARD 12B.3.1
Documented policies and procedures shall reflect the complexity of the services and commensurate with the current knowledge and evidence based practice for the ophthalmology ambulatory care services, and they are consistent with statutory requirements and the goals and objectives of the Ophthalmology Ambulatory Care Services/Centre.

CRITERION NO.	CRITERIA FOR COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
12B.3.1.1 CORE	There are written policies and procedures for the Ophthalmology Ambulatory Care Services which are consistent with the overall policies of the Facility, regulatory requirements, current standard practices and clinical practice guidelines. These policies and procedures are signed, authorised and dated. There is a mechanism for and evidence of a periodic review at least once in every three years.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Documented policies and procedures for the service.	NA				
	2.	Policies and procedures are consistent with the 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				
12B.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.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Minutes of committee meetings on development and revision on policies and procedures.	NA				
	2.	Minutes of meeting with evidence of cross reference with other departments/Centre	NA				
	3.	Documented cross departmental/centre policies	NA				
12B.3.1.3	Current policies and procedures are communicated to all staff.		NA			NA	
	EVIDENCE OF COMPLIANCE						

	1.	Training and briefing on the current policies and procedures/Minutes of meetings	NA				
	2.	Circulation list and acknowledgement	NA				
12B.3.1.4 CORE	There is evidence of compliance with policies and procedures.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Compliance with policies and procedures through:						
	a)	interview of staff on practices;	NA					
	b)	verify with observation on practices;	NA					
	c)	results of audit on practices;	NA					
	d)	practices in line with established policies and procedures.	NA					
12B.3.1.5	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Copies of relevant policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.	NA					
12B.3.1.6 CORE	There are documented policies of a planned systematic approach to the provision of ambulatory patient care. These include: a) criteria for selection and assessment of cases (refer to Day Care Surgery Standards Operating Procedure and Protocol for Day Care Anaesthesia, Ministry of Health); b) policy on the use of sedation during procedures; c) documented admission policies including age or disease limitations and the restrictions concerning the scope of clinical services offered; d) the booking and admission of patients comply with admission policies; e) essential information on the service is given to all patients; f) the requirements for a pre-anaesthetic assessment to be performed by a medical practitioner (ophthalmologist, anaesthetist, medical officer trained in anaesthesiology/ophthalmology);			NA			NA	

	g) patient identification, with the nature and site of the procedure marked and verified by the surgeon and the consent documents checked; h) observations of the patient's pre-, intra- ,and post-procedure status and vital signs are monitored and recorded in the medical record; i) pain management; j) a dedicated anaesthetist is present or readily available until all patients who have undergone general anaesthesia/deep sedation are discharged; k) the discharge procedure ensures the patient is given relevant documented postoperative instructions. l) there is a responsible person/family members accompanying the discharged patient undergone the procedures under general anaesthesia. The address and phone number of the discharge person/family members are recorded in the medical record EVIDENCE OF COMPLIANCE 1. Documented policies that address (a) to (l). NA					
12B.3.1.7	A registered medical practitioner (RMP) shall be trained to carry out procedural sedation. When performed by non-anaesthesiologists, the level of sedation should be kept at minimal to moderate. Deep sedation should ONLY be done in the presence of an anaesthesiologist throughout the procedure. EVIDENCE OF COMPLIANCE 1. Credential and privileging of registered medical practitioner carry out procedural sedation. NA 2. Policy on management of deep sedation. NA 3. Anaesthesiologist is present throughout the deep sedation procedure as observed during survey on site. NA	NA			NA	
12B.3.1.8	All patients and their relatives shall be given essential information pertaining to the procedure which include: a) the patient's pre-admission responsibilities and preparation; b) the functioning of the Ophthalmology Ambulatory Care Services;	NA			NA	

	c) type of anaesthesia and post anaesthetic effects; d) provision for after-hours contact and emergency care; e) the patient's post-discharge responsibilities/instructions; f) follow-up instruction. **EVIDENCE OF COMPLIANCE** 1. Patient information pamphlet — NA 2. Relevant contact number for any emergency care — NA 3. Patients and relatives given adequate information on the procedure carried out as evidenced as in medical records: a) pre and post-operative checklist; — NA b) written post-operative instructions; — NA c) written follow up instruction — NA					
12B.3.1.9	The policies and procedures for management of emergency patients shall include arrangement for transfer of patients, where necessary. **EVIDENCE OF COMPLIANCE** 1. Policies and procedures on management of emergency patients include: a) patient transfer; — NA b) referral details including notes on patient's medical history. — NA 2. Verification on compliance as per patient notes on transfer arrangement. — NA 3. Policy on Code Blue — NA	NA			NA	
12B.3.1.10	The Ophthalmology Ambulatory Care Services/Centre shall have a written transfer agreement/Memorandum of Understanding (MOU) with any hospital (preferable nearest hospital) whereby all registered medical practitioners performing procedure or surgery in the Ambulatory Care Centre shall have admitting privileges at such hospital. When transferring a patient to a hospital on an emergency basis, the Facility shall submit to the receiving hospital at the time of transfer a copy of all the medical records related to the patient's condition including observations of the patient's signs and symptoms, preliminary diagnosis, treatment provided, results of any tests and a copy of the informed written consent.	NA			NA	

	EVIDENCE OF COMPLIANCE					
	1.	Memorandum of Understanding (MoU) with nearby healthcare facility in management of emergency events/ written transfer agreement with hospital	NA			
	2.	Copy of 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			
12B.3.1.11	There are policies and procedures for the Theatre Sterilising Supply Unit (TSSU). The policies and procedures shall include the following: a) receiving and decontamination processes (disassembling, washing, cleaning and disinfection); b) packaging process (inspection, functionality check and packing); c) sterilisation process; d) validation processes; e) sterile storage and distribution; f) traceability and product recall; g) services provided to other healthcare facilities; h) environmental control (storage condition, effective maintenance of sterility); i) shelf life of sterile items appropriate to utilisation (turnover time); j) safety practices in TSSU ; k) utilisation of "flash" autoclave in operating theatre and clinics.		NA			NA	
	EVIDENCE OF COMPLIANCE					
	1.	Policies and procedures that address TSSU processes but not limited to items (a) to (k) are available.	NA			

12B.3.1.12	There shall be no reprocessing of any single-use medical-surgical instruments, equipment or supplies. EVIDENCE OF COMPLIANCE 1. Policy on 'No reprocessing' of any single-use medicalsurgical instruments, equipment or supplies. NA 2. Compliance with 'No reprocessing' policy. NA	NA			NA	
12B.3.1.13	Records for all activities in the processing of sterile items shall be maintained for a period of time as defined by respective regulatory authorities or in their absence as per policy of the healthcare facility. EVIDENCE OF COMPLIANCE 1. Daily production statistics to assess stock (e.g. medicalsurgical instruments, equipment or supplies) levels for safe, continuous service, efficient stock and cost control. NA 2. All tests performed on equipment and results NA 3. Steriliser records, e.g. number of cycles NA	NA			NA	

STANDARD STANDARD 12B.3.2
Patient & Family Rights

The Ophthalmology Ambulatory Care Services is responsible for providing processes that support patient and family rights from the point of accessing care.

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
12B.3.2.1	The Facility's Management, medical practitioners and other clinical and Allied Health staff work collaboratively to protect and promote Patient and Family Rights. There is documented Patient and Family Rights Policy as identified in relevant laws and regulations that include, but are not limited to: a) access to information on all services provided by the Facility/Centre; b) access to safe and medically appropriate treatment regardless of race, culture, sex, nationality, or source of payment; c) access to an interpreter if language barrier exists; d) considerate, respectful, privacy and confidential medical care; e) information of the identity of the medical practitioner and other care givers; f) reasonable information to patient and next of kin about investigations, diagnosis, treatment and prognosis, including after discharge care and continuity of care and the right to second opinion; g) participation in making informed decisions concerning care including the right to refuse proposed treatment, experimental care, participation in research projects and the right to leave the Facility/Centre against medical advice; h) appropriate counseling prior to being granted discharge from the Facility/Centre against medical advice; i) information of applicable and relevant the Facility/Centre's rules and policies; j) administration of pain management where appropriate; k) advice on the approximate cost of treatment prior to the provision of care;	NA			NA	

	l) information regarding financial and other assistance that may be available; m) receipt and examination of an itemised statement of all charges; n) information of the responsibilities of patients and families; o) access to health promotion information to facilitate their treatment in the Facility/Centre; **EVIDENCE OF COMPLIANCE** 1. There is documented Patient and Family Rights Policy as identified in the relevant laws and regulations that address items (a) to (q). — NA 2. Compliance with the Patient and Family Rights Policy as observed on site. — NA					
12B.3.2.2	There is a process designed to identify and respect patient's personal values, beliefs and religion and where applicable those of the patient's family. **EVIDENCE OF COMPLIANCE** 1. Patient's religion and beliefs are identified — NA 2. Orientation checklist addresses the needs of the patient. — NA	NA			NA	
12B.3.2.3	The Facility/Centre takes measures to protect patient's possessions from theft or loss. The Facility/Centre has a policy that indicates its responsibility for patient's possessions and a system to ensure this policy is complied with. **EVIDENCE OF COMPLIANCE** 1. Policy on patients possessions and records — NA 2. On-site observation on compliance with the above policy. — NA	NA			NA	
12B.3.2.4	The Facility/Centre has a policy on risk identification and implementation of safety measures to protect patients from injury. **EVIDENCE OF COMPLIANCE** 1. Policy on risk identification — NA 2. Risk identification strategies, e.g. security guard, closed circuit television (CCTV), fall prevention. — NA	NA			NA	
12B.3.2.5	The Facility/Centre ensures patient health information as confidential.	NA			NA	

	EVIDENCE OF COMPLIANCE						
	1.	Policy on safeguarding of patient information	NA				
	2.	Policy on release of patient's medical record.	NA				
	3.	Code of conduct of medical records staff	NA				
	4.	The following systems as observed on site:					
	a)	Secured health information system with restricted access levels	NA				
	b)	Restricted access to Medical Records Unit	NA				
	c)	System for recording and monitoring movement of medical records	NA				
12B.3.2.6	Patients are informed of their rights to voice their complaints and the grievance mechanism			NA			NA
	EVIDENCE OF COMPLIANCE						
	1.	Policy on grievance mechanism	NA				
	2.	Patient orientation checklist	NA				
	3.	Patient Charter	NA				
	4.	Brochure on Patient and Family Rights	NA				

STANDARD STANDARD 12B.3.3
Health Information Management System

The Ophthalmology Ambulatory Care Services shall have an appropriate patient's medical record system comprising of facilities, procedures and organisation for keeping patient's medical records. The Health Information Management System (HIMS) shall be organised to ensure confidentiality*, safe keeping and easy retrieval of medical records and documents both paper based and electronic related to patient care.

An accurate patient's medical record is maintained to facilitate optimal patient care and allow for evaluation of the care provided.

*Personal Data Protection Act , PDPA 2013

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
12B.3.3.1	A single record for every patient is maintained with integrated recording system by healthcare providers. A single record is a record that is a composite of all data on a given patient. Their entire medical record is in one folder under one medical record reference number. Integrated record is a system of joint recording by various healthcare providers who record information around the patient (patient based) according to sequence of events. EVIDENCE OF COMPLIANCE 1. A single record system is implemented. — NA 2. Integrated records are practiced. — NA	NA			NA	
12B.3.3.2	There is a system for patient identification, cross referencing and a filing system that allows rapid retrieval of records. EVIDENCE OF COMPLIANCE 1. Policies and procedures for patient identification, cross referencing and a filing system that allows rapid retrieval of records. — NA	NA			NA	
12B.3.3.3	There is a policy for safeguarding the information in the record against breach of confidentiality, loss, damage, or use by unauthorised personnel. There are policies and procedures on information storage and recovery including procedures for data recovery in case of malfunctions or disaster.	NA			NA	

	EVIDENCE OF COMPLIANCE					
	1.	Policy for safeguarding the information in the record against breach of confidentiality, loss, damage, or use by unauthorised personnel is in place.	NA			
	2.	Guidelines for management of medical records, electronic information system security and user access control policies (paper based and electronic information systems).	NA			
	3.	Mechanisms are in place to support Facility/Centre -wide and HIMS functions even in case of unexpected failure or	NA			
12B.3.3.4	Informed consent is obtained before surgery, anaesthesia, and other high risk treatment and procedures, and the information given shall be documented in the medical records. The informed consent shall be obtained by the medical practitioner performing the procedure.		NA		NA	
	EVIDENCE OF COMPLIANCE					
	1.	Signed consent forms. (The procedure is only performed after the consent taken.)	NA			
	2.	Evidence of documentation in medical records (explanation given at the time of taking consent)	NA			
12B.3.3.5	5 The medical practitioner records the preoperative diagnosis and there is an operative report immediately after surgery, including: a) date, time and duration; b) description of the findings; c) the procedure performed; d) tissue removed; e) tissue sent for pathological examination; f) preoperative and postoperative diagnosis; g) postoperative instructions; h) surgeon's name and signature including name of assistant where applicable		NA		NA	
	EVIDENCE OF COMPLIANCE					
	1.	Sampling of medical records to verify operative report addressing items (a) to (h).	NA			

12B.3.3.6	The patient's medical record contains information particularly relating to anaesthesia including: a) date, time and duration; b) informed consent of anaesthesia; c) evidence of a preoperative assessment by an anaesthetist, preferably by the attending anaesthetist; d) drugs and doses given during anaesthesia and route of administration; e) monitoring data; f) intravenous fluid therapy, if given; g) post anaesthetic instructions, where appropriate; h) name and signature of attending anaesthetist. EVIDENCE OF COMPLIANCE 1. Samplings of medical records and verify the notes containing anaesthetic report addressing items (a) to (h). NA	NA			NA	
12B.3.3.7	There is a policy on the retention of medical records and there are guidelines on the appropriate storage of active and inactive records. Records shall be preserved at least for the period as specified under the written law pertaining to limitation period (e.g. Statute of Limitation, National Archives Policy). EVIDENCE OF COMPLIANCE 1. Policy and guidelines on the retention of medical records NA 2. Records on medical records disposal NA 3. On-site observation on storage of medical records NA	NA			NA	

STANDARD STANDARD 12B.3.4
PREVENTION AND CONTROL OF INFECTION

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.

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
12B.3.4.1	A designated staff who has training in prevention and control of infection shall oversee all prevention and control of infection measures in the Centre. The staff in-charge has delegated authority for the supervision and effective implementation of infection control policies, and is responsible for surveillance of healthcare associated infections on a systematic and current basis. EVIDENCE OF COMPLIANCE 1. Designated nurse with training in prevention and control of infection oversee the prevention and control infection measures. — NA 2. Surveillance reports and records — NA 3. Environmental inspection records — NA 4. On-site training records conducted by staff in-charge — NA	NA			NA	
12B.3.4.2	There are safety measures taken to ensure the protection of the Facility's staff and environment against healthcare associated infections. Records shall be kept on action taken which include: a) staff education; b) staff health screening including infectious diseases; c) staff immunisation; d) staff health record maintenance; e) provision for adequate and good quality personal protective equipment (PPE); f) implementation of safety devices; g) clinical waste management; h) environmental infection risk; i) protocol for post-exposure management for infectious disease and for assignment of infected staff. EVIDENCE OF COMPLIANCE	NA			NA	

	1.	Where appropriate, records are kept on actions taken which include items (a) to (i).	NA				
12B.3.4.3	Provision is made for the personal comfort and safety of patients and staff which include: a) clean and hygienic facilities; b) room temperatures are kept at comfortable levels; c) disinfection and sterilisation areas; safe equipment and instruments; d) proper hand hygiene facilities; e) aseptic techniques for procedures; f) practice of standard and additional precautions.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	There is evidence of items (a) to (f) being implemented.	NA					
12B.3.4.4	There are written infection control policies and procedures relevant to the scope of services, complexity of the Facility and level of risks consistent with national and international requirements. There is evidence of compliance with policies and procedures and evidence based guidelines (World Health Organization/Centers for Disease Control and Prevention/Ministry of Health).			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	On-site observation for Infection control practices	NA					
	2.	Audit reports on infection control practices	NA					
	3.	Incident reports related to infection control	NA					
	4.	Staff health report on cases related to infection control	NA					
	5.	National and local antibiotic guidelines	NA					
12B.3.4.5	All anaesthetic procedures shall comply with standard infection control guidelines to prevent cross infection between patients. Breathing apparatus shall not be shared and disposable items shall not be reused.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Guidelines on infection control policy in the operating theatre are available and adhered to.	NA					
	2.	Reusable anaesthetic items and equipment are sterilised according to infection control guidelines.	NA					
	3.	Single use anaesthetic items are disposed after each use.	NA					

12B.3.4.6	The Person In Charge (PIC) and designated nurse in-charge of infection control shall take necessary measures to ensure that: a) proposed demolition, building constructions and renovations are designed in line with accepted infection control requirements; b) proposed new equipment intended for patient care conforms to accepted infection control standards. EVIDENCE OF COMPLIANCE 1. Records on input PIC and nurse in-charge of infection control for (a) and (b) where applicable. — NA	NA			NA	
12B.3.4.7	The Person In Charge (PIC) and designated nurse in-charge of infection control reviews reports on healthcare associated infections rates, surveillance studies of infections and infection potentials, and the implementation of infection control policies. Pertinent findings shall be submitted to the appropriate source for necessary action. EVIDENCE OF COMPLIANCE 1. Minutes of Infection Control Committee meeting — NA 2. Reports on:- a) healthcare associated infection rates; — NA b) surveillance data on infections and infection potentials; — NA c) implementation of infection control policies — NA 3. Records on pertinent findings submitted to the appropriate source for necessary action to be taken. — NA	NA			NA	

STANDARD STANDARD 12B.3.5
PHARMACY SERVICES

The Pharmacy Services shall be organised and administered to provide efficient pharmaceutical care services including the purchase, distribution, and control of pharmaceutical products; and to disseminate appropriate drug information to the healthcare team and patients of the Facility in accordance with prevailing standards of pharmacy practice.

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
12B.3.5.1	There are policies and procedures on ordering and administering of medicines which include: a) incorporation of patient medication orders into the patient's medical record; b) recording in the patient's medical record for every dose of medicine administered; c) keeping accurate and accessible records on medicines supplied and administered to inpatients and outpatients; d) administering of medicines brought into the Facility/ Centre by patients; e) administering of medicines by patients, where appropriate; f) access to patients' medical records, where appropriate; g) abbreviations where used are in accordance with an approved list and this list is endorsed by the Person In Charge (PIC); h) reconstitution, storage, transportation and administration of cytotoxic drugs (where applicable).	NA			NA	
	EVIDENCE OF COMPLIANCE					
	1. Policies and procedures on ordering and administering of medicines include (a) to (i). — NA					
	2. Prescription patterns — NA					
	3. Medication administration — NA					
	4. Patient medication record — NA					
	5. Records on order, worksheet, preparation, supply and transportation of cytotoxic drug. — NA					
	6. Drug reconciliation policy — NA					
12B.3.5.2	There are documented policies and procedures on prescribing medication that state:	NA			NA	

	a) medicines can only be dispensed by qualified pharmacy personnel based on written order from the medical practitioner; b) electronic prescribing, using an open or closed network if practiced, conform to established conventions with regards to the identity of the prescriber and patient; c) drugs dispensed and administered are based on the original of the medical practitioner's order. Drug orders are not transcribed. **EVIDENCE OF COMPLIANCE** 1. Policies and procedures include (a) to (c) are available. — NA 2. Security access is established for electronic prescribing. — NA 3. Records on original prescription. — NA 4. Updated sample of doctors' signature for manual prescribing. — NA					
12B.3.5.3	There is adverse drug reaction reporting system in place. Policies and procedures for Adverse Drug Reaction (ADR) Reporting shall include the method of detection, a mechanism for reporting to the medical practitioner, the pharmacist, the Adverse Drug Reaction Advisory Committee/appropriate internal committee (where applicable). **EVIDENCE OF COMPLIANCE** 1. Appropriate committee to discuss the ADR incidents. — NA 2. Policies and procedures are in place for ADR reporting — NA 3. Sample of ADR reports and dissemination of findings — NA	NA			NA	
12B.3.5.4	There is a system for reporting of medication errors, identifying the root cause and corrective action taken to prevent similar errors. **EVIDENCE OF COMPLIANCE** 1. Standard operating procedures for reporting of medication error — NA 2. Sample of medication error report — NA 3. Evidence of corrective action taken and dissemination of findings. — NA	NA			NA	

TOPIC TOPIC 12B.4
FACILITIES AND EQUIPMENT

STANDARD STANDARD 12B.4.1
There are adequate physical facilities and equipment for safe and efficient functioning of the Ophthalmology Ambulatory Care Services. The services may operate from a purpose-built facility with designated rooms such as ophthalmology clinics (including facility providing diagnostic services), day care wards, operating theatre (with Anaesthetic Services and without Anaesthetic Services) and Central Sterilising Supply Services.

CRITERION NO.	CRITERIA FOR COMPLIANCE			SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
12B.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.	Facilities for Ophthalmology Ambulatory Care Services include the following:						
	a)	adequate working space with suitable lighting;	NA					
	b)	storage space for equipment, surgical supplies, linen, housekeeping equipment, and pharmaceutical supplies, including the storage of dangerous and psychotropic drugs;	NA					
	c)	easy access;	NA					
	d)	facilities for disabled persons;	NA					
	e)	vehicle access to facilitate the safe admission and discharge of patients;	NA					
	f)	adequate provision for emergency power and uninterrupted power supply (UPS) where indicated.	NA					
	g)	adequate facilities and equipment at each patient care area for safe care. (e.g. defibrillators, emergency cart, hand washing facilities etc)	NA					
12B.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 Ophthalmology Ambulatory Care Services, e.g. wards, treatment rooms, dirty and clean utility rooms, access, lighting, signage, etc address the safety aspects of patients and staff.	NA					

	2.	At least a short-stay drop off and pick up point immediately adjacent to the unit and ward.	NA				
	3.	Adequate equipment and supplies for Ophthalmology Ambulatory Care Services, e.g. emergency trolley, functioning patient call bell, etc.	NA				
	4.	Equipment should have scheduled planned preventive maintenance (PPM).	NA				
12B.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				
12B.4.1.4	There is documented evidence that equipment and instruments complies with relevant national/international standards and current statutory requirements. All biomedical equipment shall comply with Medical Device Act 2012.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Testing, commissioning and calibration records (certificates or stickers)	NA				
	2.	Certification of equipment and instruments 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				
	3.	Medical device registration certificate from Medical Device Authority.	NA				
12B.4.1.5 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				

12B.4.1.6	Emergency biomedical equipment is thoroughly tested as a routine, e.g. defibrillators are discharged and output checked every day or after each use, and the results recorded. EVIDENCE OF COMPLIANCE 1. Records on regular inspection and checking biomedical equipment (electrocardiogram strips for defibrillator) — NA 2. Policy and schedule on checking biomedical equipment — NA	NA			NA	
12B.4.1.7	Where specialised equipment (e.g. optical radiation devices, etc) is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment. EVIDENCE OF COMPLIANCE 1. User training records — NA 2. Competency assessment record — NA 3. Letter of authorisation — NA 4. List of staff trained and competent to operate specialised equipment — NA	NA			NA	
12B.4.1.8	Equipment is upgraded (based on evidence) from time to time to keep pace with advancement in operative and diagnostic techniques and technology. 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	NA			NA	

STANDARD STANDARD 12B.4.2
FACILITIES FOR OUTPATIENT SERVICES

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
12B.4.2.1	The Ophthalmology 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) adequate provision is made for patient comfort		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	The Ophthalmology 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				
12B.4.2.2	Adequate numbers of rooms are provided to ensure patient privacy and confidentiality for various patient care activities including: a) consultation (not more than one patient in a room at any time); b) conduct of minor procedures and nursing procedures; maintain a register of procedures performed; c) performance of various tests.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Adequate facilities for consultation and patient care activities that address (a) to (c) with evidence of but not limited to the following:						
	a)	privacy of patient is ensured;	NA					
	b)	procedure room is appropriately equipped;	NA					
	c)	patient monitoring device is available where required;	NA					
	d)	list of procedures done.	NA					
12B.4.2.3	When an optometrist is present, examination room shall be set up according to standards to enable precise measurement.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	List of Standard and Alternative Facilities in the Optometry Standard Operating Procedures is to be used as reference in setting up of Optometry examination room.	NA					
	2.	Observation on-site during survey	NA					

STANDARD STANDARD 12B.4.3
FACILITIES AND EQUIPMENT FOR DAY CARE WARD

Adequate facilities and equipment shall be available to provide safe and effective patient care in the day care ward.

CRITERION NO.	CRITERIA FOR COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
12B.4.3.1	Facilities are suitably located to facilitate easy access and to provide an atmosphere of user, environmental and 'disabled' friendly. **EVIDENCE OF COMPLIANCE** 1. Floor plan indicates accessibility and patient and user friendly. — NA 2. Feedback from patient experience — NA 3. Incident reporting relating to facilities if any — NA		NA			NA	
12B.4.3.2	Equipment, both for emergency and non-emergency usage, shall be appropriate to the level of care. **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 signs monitor, functioning patient call bell, etc. — NA 2. Proper cleaning / washing facilities for equipment — NA 3. Proper disinfection, sterilisation and storage facilities for instruments. — NA 4. Adequate medical gas and suction supplies — NA 5. Fire extinguishers at relevant areas — NA 6. Scheduled checking of items in emergency trolley — NA		NA			NA	
12B.4.3.3	The day care ward of Ophthalmology Ambulatory Care Services shall comply with all safety features in accordance with regulatory requirements which include: a) electrical equipment complies with relevant electrical standards on the safe use of electricity in patient care; b) staff are aware of the appropriate procedures in the safe use and application of electromedical equipment;		NA			NA	

c) regular maintenance and monitoring of facilities and equipment, and a system to respond to breakdown repair and replacement;

d) emergency biomedical equipment, e.g. defibrillator is checked at least once a day or after each use and the result is recorded;

EVIDENCE OF COMPLIANCE		
1.	Certification or label of safety standards for equipment as required by law.	NA
2.	Awareness training of staff on use of and application of electromedical equipment.	NA
3.	Planned Preventive Maintenance (PPM), calibration and repair records	NA
4.	Defibrillator calibration testing record	NA

STANDARD STANDARD 12B.4.4
Operating Theatre for Ophthalmology Ambulatory Care Services

There are adequate and appropriate physical facilities and equipment for the safe and efficient functioning of the operating theatre (OT) facilities. Day care anaesthesia services shall be provided in an integrated set up using the dedicated operating theatres when applicable.

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
12B.4.4.1	The design of the operating suite provides adequate space for the reception, anaesthesia induction, surgery, post-surgical recovery and observation of patients. This shall include not limited to: a) suitable areas for reception and for patients awaiting surgery; b) operating theatres; c) recovery area; d) adequate storage space for equipment, surgical supplies, linen, housekeeping equipment, and pharmaceutical supplies, including dangerous and psychotropic drugs; e) areas for administrative office, and where required, teaching facilities; f) areas for the collection and disposal of used equipment and waste; g) male and female staff change rooms; h) staff facilities, e.g. tea room, locker area; i) there is plan for providing improved staff facilities when the Facility undergoes refurbishment or redevelopment if any of the above are deemed inadequate.	NA		NA		

EVIDENCE OF COMPLIANCE		
1.	The design and layout of the operating suite provide adequate space and includes features as listed in (a) to (i).	NA
2.	Adequate recovery bay is available for post-operative cases.	NA

12B.4.4.2	The design of the operating theatre supports efficient systems for the management of perioperative services which include: a) operating rooms are treated as "clean" rooms with yearly performance test undertaken to ensure "clean" room status is maintained; b) ventilation system should provide positive pressure from the cleanest areas to less clean area; c) definitive traffic flow patterns and demarcation of sterile and non-sterile zones which enable enforcement of sterility discipline; d) ready access for routing emergency patients; e) fire detection, alarm, and suppression systems; firefighting equipment and appropriate sign posting; f) adequate means of egress from the operating suite in the event of fire; g) free movement of patient trolleys/wheelchairs throughout the suite with a minimum of cross traffic; h) reception of the patient in close proximity to the junction of sterile and non-sterile zones (air-lock zone); i) uninterrupted power supply (UPS) system in operating theatres shall be provided with an alarm system at the reception counter which will be triggered when the system is not charged; j) the medical gas system in the operating theatres shall be monitored to ensure that it is functioning; k) the quantity of medical gas terminal units be sufficient as required under national and international standards; l) colour coding for electrical outlets shall be according to international standards. EVIDENCE OF COMPLIANCE 1. The design and layout of the operating theatre provide adequate space and includes features as listed in (a) to (l) — NA	NA			NA	

	2.	Internal air quality report (IAQ),	NA				
	3.	Temperature (18ºC-22ºC) and humidity (50%-60%) are monitored.	NA				
	4.	Air change per hour (at least 20 air changes per hour)	NA				
	5.	Fire escape plan clearly posted.	NA				
	6.	Verification of the appropriateness of the design of the operating suite by on-site inspection.	NA				
	7.	Log book on medical gas monitoring	NA				
12B.4.4.3	The requirements for other systems to support perioperative services include: a) adequate numbers of general power outlets distributed according to needs of each area; b) adequate provision for emergency power outlets for lighting and suction of an appropriate nature complying with current Malaysian Standards; c) suitable lighting; d) adequate medical gas and suction supplies complying with current Malaysian Standards; e) a means of environmental control of temperature and humidity within safe limits for anaesthetised patients undergoing surgery/procedures. *Note:* Environmental control shall ensure that air quality complies with relevant standards for various treatment or functional areas in respect of temperature, relative humidity and particle count.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Verification of other support systems in the operating suite includes items listed (a) to (e).	NA				
	2.	Evidence of minimum of two suction ports (one for anaesthesia and one for surgeon) per operating room. (If inadequate, then there must be portable suction devices for operating theatre needs)	NA				
	3.	Temperature maintained at 18°C - 22°C and relative humidity 50% - 60%.	NA				
12B.4.4.4	The operating theatre shall comply with all safety features in accordance with regulatory requirements which include:		NA			NA	

	a) scavenging of anesthetic gases and vapors where general anaesthesia is provided; b) regular maintenance and monitoring of facilities and equipment, and a system to respond immediately to breakdown, repair, and replacement; c) electrical equipment which comply with Malaysian Standards; d) appropriate personal protective equipment are provided in the presence of biohazards or laser procedures. **EVIDENCE OF COMPLIANCE** 1. The operating theatre complies with all safety features in accordance to regulatory requirements as addressed in (a) to (d). — NA 2. Verification of the above through on-site inspection. — NA 3. Warning signs is placed outside the operating theatre if laser is in use. — NA					
12B.4.4.5 CORE	The requirements for equipment used in the operating theatre shall include the following: a) a range of basic and specialised ophthalmology equipment in quantities sufficient to support the ophthalmology programme; b) where loan equipment is required, the loan equipment shall be delivered at least 48 hours to the Facility for appropriate decontamination/disinfection/sterilisation to be done before use; c) where general anaesthesia is provided, minimum standards for monitoring in anaesthesia as defined by the Malaysian Society of Anesthesiologists or the College of Anaesthesiologists of the Academy of Medicine of Malaysia (current edition); d) emergency and resuscitation equipment and supplies; with clearly defined instructions on how to operate the equipment and there is evidence that staff are trained to use the equipment. **EVIDENCE OF COMPLIANCE**	NA			NA	

	1.	The requirements for equipment used in the Operating Suite Services shall include items (a) to (d).	NA				
	2.	Verification of above through on-site inspection	NA				
	3.	Policy on handling and maintenance of loan equipment	NA				
	4.	Resuscitation drugs and equipment are in accordance to "Recommendations for Patient Safety and Minimal Monitoring Standards during Anaesthesia and Recovery' (Current Edition).	NA				
	5.	Presence of difficult intubation trolley, complete with airway devices and algorithm for CICV (can't intubate, can't ventilate) scenario where applicable.	NA				
	6.	Protocol for management of malignant hyperthermia (MH) and local anaesthetic toxicity, including statement on accessibility of drugs to treat these specific conditions are available where applicable.	NA				
12B.4.4.6	Where general anaesthesia is provided, there shall be adequate space for patient recovery from anaesthesia with minimum 1 recovery bay to 1 operating room (current MOH Day Care Surgery SOP). The recovery room shall be appropriately staffed and equipped for resuscitation and monitoring. The nurse to patient ratio shall be based on patient's conscious level i.e.1:1 for unconscious patient and 1:3 for conscious patients.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	The patient recovery area is in the vicinity of the operating room and readily accessible to the anaesthetist.	NA				
	2.	Availability of resuscitation equipment in case of emergency.	NA				
	3.	Adequate number of nurses according to norms and suitably qualified and trained to assist in anaesthetic emergencies.	NA				
12B.4.4.7	Anaesthetic delivery systems shall be kept in good condition with regular maintenance and there is a system to respond immediately to breakdown repair.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Documented evidence of maintenance records on all equipment used in the delivery of anaesthesia	NA				
	2.	System on respond to breakdown repair	NA				
12B.4.4.8 CORE	All patients who are anaesthetised shall have adequate monitoring as specified by the document "Safety Standards for Anaesthesia and Recovery" published by the Malaysian Society of Anaesthesiologists. The monitoring shall include the minimum		NA			NA	

	of monitoring of electrocardiogram (ECG), blood pressure, pulse, respiration, oxygen saturation, capnometry and others as may be necessary. EVIDENCE OF COMPLIANCE 1. Compliance to standard guidelines on monitoring of anaesthetised patients, i.e. “Safety Standards for Anaesthesia and Recovery”. NA						
12B.4.4.9	Anaesthetic delivery systems shall have safety features to prevent accidental hypoxia or disconnection of breathing circuits during mechanical ventilation. These will include antihypoxic devices, alarms for oxygen pressure failure, and ventilator disconnect alarms. EVIDENCE OF COMPLIANCE 1. Availability of general anaesthesia (GA) machines with the required safety features. NA	NA			NA		
12B.4.4.10	Anaesthetic waste gases and vapours shall be scavenged. EVIDENCE OF COMPLIANCE 1. Evidence of functional Anaesthetic Gas Scavenging Systems NA	NA			NA		
12B.4.4.11	An emergency alert shall be available within the operating suite area to call for assistance in the event of a serious adverse event in any operating room. EVIDENCE OF COMPLIANCE 1. Availability of emergency alert NA	NA			NA		

STANDARD STANDARD 12B.4.5
Theatre Sterilising Supply Unit (TSSU)

The TSSU in the Ophthalmology Ambulatory Care Services/Centre is appropriately designed, installed and operated with adequate facilities and equipment to the needs of the services to assure that reprocessed medical devices and other sterilised products achieve high assurance levels of sterility.

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
12B.4.5.1 CORE	The design and set up of the Theatre Sterilising Supply Unit allows for: a) The TSSU to be equipped and arranged to provide proper separation of clean and dirty routes and processes with clear demarcation of the different zones. The airflow is from clean to soiled areas. b) Areas within TSSU shall be adequate to provide for: i) Receiving of unsterile supplies • Facilities for receiving, disassembling and cleaning of supplies and equipment shall be appropriately located avoiding non-sterile items passing through sterile areas of the TSSU. ii) Assembling and Packaging • Facilities for assembling, packaging supplies and equipment shall have hand hygiene facilities, work counter (a non-porous material work benches) or its equivalent as required by types and volume of items. iii) Sterilisation • Facilities for sterilising shall be located between packaging area and sterile storage area. iv) Adequate storage areas for sterile instruments and supplies, unsterilised linen, unsterile instruments, equipment and surgical supplies and chemical detergents and disinfectants. c) Hand washing facilities d) Staff changing room are readily available. e) Suitably planned layout of work benches and equipment. EVIDENCE OF COMPLIANCE 1. The design and set up of the TSSU address all items (a) to (e) as per relevant regulations and as evidenced by:	NA			NA	

	a)	demarcation with physical structure between the operating theatre and TSSU; there should be no crisscrossing of non-sterile and sterile items;	NA				
	b)	appropriate areas that facilitates the activities of sterilisation supply services;	NA				
	c)	compliance with Infection Control Policies and practices;	NA				
	d)	appropriate work benches at assembling and packaging area.	NA				
12B.4.5.2	All sterilising systems (e.g. mechanical and chemical system) are maintained in accordance with statutory regulations.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Manual and log book of mechanical sterilising system	NA				
	2.	Planned preventive maintenance schedule and records	NA				
12B.4.5.3 CORE	There are special automated equipment appropriate to the TSSU for the cleaning, drying, and sterilisation of surgical micro equipment, and they comply with acceptable standards.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Appropriate equipment to match complexity of the facility's services such as:					
	a)	washer disinfector;	NA				
	b)	ultrasonic washer;	NA				
	c)	dryer;	NA				
	d)	heat sealing equipment;	NA				
	e)	rapid biological test incubator.	NA				
12B.4.5.4 CORE	Validation on sterilisation process using mechanical, chemical and biological tests are conducted and results monitored and recorded accordingly.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Performance of relevant tests and results:					
	a)	mechanical test results records;	NA				
	b)	chemical test result records;	NA				
	c)	biological test result records	NA				

	2.	Records on deviations if any and corrective and preventive actions taken.	NA					
	3.	Relevant efficacy test records considering mechanical aspects, chemical aspects, temperature and time.	NA					

STANDARD STANDARD 12B.4.6
Linen Services

The Linen Services include the supply and delivery of clean linen and the collection and off site washing of dirty and soiled linen.

For stand-alone Ophthalmology Ambulatory Care Services, the use of disposable surgical linen is advisable to ensure sterility. If reusable surgical linen is used, a monitoring system shall be in place which comply with Prevention and Control of Infection standards.

There is adequate supply of clean linen/disposable surgical linen and protective clothing in the Ophthalmology Ambulatory Care Services. They are properly handled and stored in such a way as to avoid re-absorption of moisture and contamination from surface contact or airborne.

CRITERION NO.	CRITERIA FOR COMPLIANCE			SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
12B.4.6.1	The patient shall be in clean linen throughout the procedure.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Policy on linen supply	NA					
	2.	Patients have clean linen as evidenced on-site.	NA					
12B.4.6.2	Soiled linen is collected in such a manner as to avoid microbial dissemination and it is placed in segregated bags or containers at the site of collection.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Policy on management of soiled linen	NA					
	2.	Soiled linen is collected in dedicated colour coded linen bag as observed on inspection.	NA					
	3.	Adequate supply of alginate bag for contaminated linen	NA					
12B.4.6.3	Soiled linen from infectious patients is clearly identified; staff shall take appropriate precautions in handling and processing this type of linen.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Policy on handling contaminated linen	NA					
	2.	Use of colour coded linen bag for different types of linen	NA					
	3.	Use of alginate bag for contaminated linen as evidenced on site	NA					

12B.4.6.4	Written procedures are in accordance with acceptable standards for handling and processing linen and shall cover the following: a) processing techniques including handling and collecting of dirty linen and transporting prior to washing; b) physical appearance and condition of linen. EVIDENCE OF COMPLIANCE 1. Policies and Procedures on Linen Services that address but not limited to items (a) to (b) are available. — NA	NA			NA	
12B.4.6.5	Clean linen is transported and stored separately from soiled linen. EVIDENCE OF COMPLIANCE 1. Policy on transporting and storing of clean linen — NA 2. Schedule on cleaning containers used for transporting clean linen. — NA 3. Records on cleaning containers used for transporting clean linen. — NA 4. Dedicated clean linen storage area. — NA	NA			NA	

TOPIC TOPIC 12B.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD STANDARD 12B.5.1
The Head of Ophthalmology Ambulatory Care Services/Centre shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Ambulatory Care Services/Centre. The Head of Ophthalmology Ambulatory Care 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
12B.5.1.1	The Head of the Ophthalmology Ambulatory Care Services/Centre shall ensure the provision of high quality performance through ongoing patient safety, quality improvement and risk management programmes of the Facility. EVIDENCE OF COMPLIANCE 1. Plans for patient safety, quality improvement and risk management. — NA	NA			NA	
12B.5.1.2	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Ophthalmology Ambulatory Care 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. 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	NA			NA	

	4.	Performance improvement studies	NA				
	5.	Mortality and morbidity audits with remedial actions	NA				
	6.	Records on innovation if available.	NA				
12B.5.1.3	The Head of Ophthalmology Ambulatory Care Services/Centre 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				
12B.5.1.4	The Head of the Ophthalmology Ambulatory Care Services/Centre 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				

12B.5.1.5 CORE	The Ophthalmologist Ambulatory Care Services/Centre shall address Patient Safety Goals to prevent potential errors from occurring. World Health Organization (WHO) Global Patient Safety Challenges 1. Identify patient correctly 2. Improve effective communication 3. Improve the safety of high-alert medications 4. Ensure correct-site, correct-procedure, correct-patient surgery 5. Reduce the risk of healthcare associated infections 6. Reduce the risk of patient harm resulting from fall World Health Organization (WHO) Patient Safety Solutions 1. Look-Alike, Sound-Alike Medication Names 2. Patient Identification 3. Communication During Patient Hand-Overs 4. Performance of Correct Procedure at Correct Body Site 5. Single Use of Injection Devices 6. Improved Hand Hygiene to Prevent Healthcare Associated Infections Malaysian Patient Safety Goals 1. To implement Clinical Governance 2. To implement the WHO's 1st Global Patient Safety Challenge: "Clean Care is Safer Care" 3. To implement the WHO's 2nd Global Patient Safety Challenge: "Safe Surgery Saves Lives" 4. To improve the accuracy of patient identification 5. To ensure medication safety 6. To improve clinical communication by implementing critical value programme 7. To reduce patient fall 8. To implement an Incident Reporting and Learning System EVIDENCE OF COMPLIANCE 1. Report on implementation of WHO Global Patient Safety Challenges & Patient Safety Solutions and Malaysian Patient Safety Goals. NA	NA			NA	
12B.5.1.6 CORE	There is tracking and trending of specific performance indicators of the following:	NA			NA	

	a) Percentage infectious endophthalmitis following cataract surgery (Target: < 0.2%, 2 cases per 1000 operations) b) Percentage of patients with post-operative visual acuity of 6/12 or better within 3 months following cataract surgery and refractive procedure in patients without ocular co-morbidity (Target: >85%)					
	EVIDENCE OF COMPLIANCE					
	1.	Specific performance indicators monitored.	NA			
	2.	Records on tracking and trending analysis.	NA			
	3.	Remedial measures taken where appropriate.	NA			
12B.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			
12B.5.1.8	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.		NA		NA	
	EVIDENCE OF COMPLIANCE					
	1.	Documentation on performance improvement activities and performance indicators.	NA			
	2.	Policy statement on anonymity on patients and providers involved in performance improvement activities.	NA			

TOPIC TOPIC 12B.6
SPECIAL REQUIREMENTS

STANDARD STANDARD 12B.6.1
Waste Management

The disposal of domestic, clinical and recycled wastes is carried out in accordance with legislation requirements of the Department of Environment and local authority.

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
12B.6.6.1	Waste management a) Waste disposal shall be in accordance with national and local regulations. Waste generated by the sterilising supply services shall be placed in appropriate containers/bags. b) All contaminated waste such as: i) soiled surgical dressings, e.g. cotton wool, gloves, swabs; ii) human tissue shall be discarded into appropriate containers and disposed in accordance with the regulatory requirements. c) Used vials of biological indicators for monitoring of sterilisation shall be disposed in accordance with the regulatory requirements. d) Appropriate size of sharps containers shall be provided for disposal of condemned needles, used single needles and syringes, blades and other disposable sharp items. The collection container must be puncture resistant and leak tight. This category of waste has to be disposed/destroyed completely as to prevent potential risk of injury/infection. e) All clinical waste should be removed from the operating theatre and sterilising supply services via a designated disposal exit for incineration. f) Availability of hand washing facilities in storage area.	NA		NA		

EVIDENCE OF COMPLIANCE		
1.	Policy on segregation, collection and storage of waste	NA
2.	Planned schedule for waste disposal by facility/centre	NA

	3.	Dedicated route	NA				
	4.	Record of waste collection	NA				
	5.	Contract for clinical waste disposal	NA				
12B.6.6.2	Cytotoxic wastes shall be segregated at the point of origin, appropriately labelled during collection in compliance with the relevant regulations and guidelines, collected in approved colour-coded bags by appropriately trained staff, stored in designated storage facility with proper temperature controls, and with hand washing facility and wastewater drainage.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Cytotoxic wastes are properly labelled and not mixed with other wastes.	NA				
	2.	Appropriate storage facilities for cytotoxic wastes.	NA				
	3.	Spillage kits	NA				
12B.6.6.3	Staff that handle chemicals and healthcare facility wastes need to be trained on proper handling and disposal of such wastes.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Records on staff training	NA				
12B.6.6.4	Staff shall wear appropriate personal protective equipment when handling hazardous materials.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Staff and contractors wear appropriate personal protective equipment.	NA				
12B.6.6.5	Chemicals and healthcare wastes shall be appropriately stored as follows: a) inflammable, acid/base chemicals shall be kept separately in metal cabinets; b) the chemical and scheduled waste store shall be well ventilated and equipped with spillage containment; c) the clinical waste store shall be refrigerated if the wastes are stored for more than 24 hours.			NA			NA	
	EVIDENCE OF COMPLIANCE							

	1.	Proper storage of chemicals in appropriate and right size cabinets and/or rooms.	NA				
	2.	Clinical waste store is refrigerated at temperature 4°C - 6°C if the wastes are stored for more than 24 hours.	NA				

STANDARD STANDARD 12B.6.2
FIRE SAFETY

The buildings of Ophthalmology Ambulatory Care Services shall be designed, constructed, equipped, operated and maintained in compliance with the relevant Acts, Statutory Regulations and Standards, ensuring safety to patients, visitors, staff and property from damages due to fire.

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
12B.6.2.1	The building shall be equipped with active and passive fire protection system such as fire detection and suppression system, in compliance with statutory regulations, standards and professional best practices relating to fire safety. For buildings built after 1990, the fire detection systems shall be integrated and linked to the nearest fire station designated by the Fire Authority. *Note: Refer to Fire Services Act 1988* EVIDENCE OF COMPLIANCE 1. Building drawing approved by Fire Authority for buildings built after 1990. — NA 2. Continuous Monitoring Information System (CMIS) is functional and linked to the fire station where applicable. — NA	NA			NA	
12B.6.2.2	There is documented evidence that all buildings have been inspected by the Fire Authority annually and all risk issues identified during the inspections have been rectified to the satisfaction of the Fire Authority concerned. *Note: Refer to Fire Service Act 1988* EVIDENCE OF COMPLIANCE 1. Annual fire inspection report by Fire Authority — NA 2. Current Fire Safety Certificate is available for buildings built after 1990. — NA 3. Facility's report on rectification of recommendations by Fire Authority where required. — NA	NA			NA	
12B.6.2.3	Fire fighting equipment/system, such as fire extinguishers, hydrants, hose reels, fire blankets and fire suppression system are located at appropriate locations as per Fire Authority's requirements.	NA			NA	

	The systems are in proper functioning condition, and are being maintained and tested regularly, at least once every three (3) months or as required. EVIDENCE OF COMPLIANCE 1. Fire extinguishers have valid inspection certificates — NA 2. Testing of fire extinguishers — NA 3. Maintenance records — NA					
12B.6.2.4	There are clear signages to indicate the location of fire fighting equipment and general instructions to use the equipment during emergency. EVIDENCE OF COMPLIANCE 1. Signages indicating fire fighting equipment are clearly visible. — NA	NA			NA	
12B.6.2.5	All doors, corridors, ramps, and emergency stairways along the designated fire escape routes shall be kept free of obstruction at all times. EVIDENCE OF COMPLIANCE 1. Fire exit routes are unobstructed. — NA	NA			NA	
12B.6.2.6	All fire escape routes and fire exit doors shall be identified with lighted "KELUAR" or "EXIT" sign as stipulated in the Fire Authority's regulations. EVIDENCE OF COMPLIANCE 1. KELUAR / EXIT signs are: a) clearly visible; — NA b) functional; — NA c) adequate. — NA	NA			NA	
12B.6.2.7	The evacuation route floor plans shall be displayed at the entrances of every department. The assembly areas have to be a secured open space at a safe distance away from the building. There is signage to direct evacuees to the assembly area in case the assembly areas could not be seen when evacuees exiting the building. EVIDENCE OF COMPLIANCE 1. Current evacuation plans are available. — NA	NA			NA	

	2.	Clear signage to assembly areas	NA				
12B.6.2.8	There are adequate "No Smoking" signs posted at all entrances to the Facility.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	No Smoking" signs are:						
	a)	visible;	NA					
	b)	adequate;	NA					
	c)	placed at all entrances to the Facility.	NA					
12B.6.2.9	There is at least one designated Fire Safety Officer assigned by the Person In Charge. The Fire Safety Officer(s) shall have the relevant training to ensure that they can be responsible for fire safety at the Facility all times.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Assignment letter	NA					
	2.	Training records	NA					
	3.	Minutes of fire safety meetings	NA					
12B.6.2.10	There is documented evidence that fire drills have been planned for every year, and the drills are held; minimum once in the current year, involving different sections of the service and conducted under varied conditions. There are written reports and evaluations on all drills, and documentation of staff attendances.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Records and reports on annual fire drills	NA					
	2.	Staff attendance list	NA					
12B.6.2.11	The general contingency plan for fire and evacuation shall be understood by all staff and in-house contractors and tenants. Key assigned personnel shall be trained in more advanced aspects of fire safety, including fire notification procedures, fire alarm, use of fire fighting equipment, fire evacuation procedures and evacuation of non-ambulant patients.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Staff awareness on fire and evacuation plan	NA					
	2.	Records on training of key assigned personnel and staff on specific aspects of fire safety	NA					

STANDARD STANDARD 12B.6.3
DISASTER MANAGEMENT

There shall be a disaster management system that supports safe practice and a safe environment:

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
12B.6.3.1	The Facility/Centre shall have documented internal disaster plan for all anticipated occurrence of incidences that would have adverse effect on patients, visitors and staff as follows, where applicable: a) Fire/Explosion b) Bomb threat c) Evacuation d) Physical Assault/Security Threat e) Facilities system failure f) Major chemical spillage/radiation leaks g) Medical Emergencies h) Emergencies in Operating Rooms i) Flood j) Disease outbreak	NA			NA	

EVIDENCE OF COMPLIANCE		
1.	Internal Disaster Plan that include potential internal disasters (a) to (j)	NA
2.	List of relevant agencies and their contact numbers	NA
3.	Adequate resources as per disaster plan	NA
4.	Records on relevant staff training on the Internal Disaster Plan	NA
5.	Reports on the Internal Disaster Drill that carry out once a year.	NA

12B.6.3.2	A code system normally using colour as identifier is used to identify the emergency status to avoid unnecessary panic if the code is announced via public address system. EVIDENCE OF COMPLIANCE 1. Specified colour codes for internal disaster — NA	NA			NA	

SERVICE SUMMARY	
-	
OVERALL RATING :	NA
OVERALL RISK :	-