SERVICE STANDARD 17 : REHABILITATION MEDICINE SERVICES

PREAMBLE
Rehabilitation Medicine Services are clinical speciality services offering inpatient as well as outpatient clinical care and rehabilitation for individuals whose abilities have been limited by disease, trauma or congenital disorders.

It is a medical specialty concerned with evaluation, diagnosis and management of individuals of all ages with physical and cognitive impairment resulting in disability. This specialty involves treatment of individuals with functional limitation emphasising on functional attainment while also addressing prevention of complication.

Rehabilitation Medicine Specialist provide leadership to multidisciplinary teams concerned with optimal restoration of function via physical, psychological, social, occupational, vocational and avocational interventions.

TOPIC TOPIC 17.1
ORGANISATION AND MANAGEMENT

STANDARD STANDARD 17.1.1
The Rehabilitation Medicine Services shall be organised, directed and coordinated with other services in the Facility to provide a standard of inpatient and outpatient care to the community which is efficient, effective, and in a caring manner and with due regard for the needs, dignity and privacy of patients and confidentiality of their personal information. The Rehabilitation Medicine Services shall be easily accessible and continuity of care assured.

CRITERION NO.	CRITERIA FOR COMPLIANCE			SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
17.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Rehabilitation Medicine 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 Rehabilitation Medicine 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				
17.1.1.2 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 Rehabilitation Medicine Services, consultants, medical practitioners and staff of the Rehabilitation Medicine Services; b) reflect the link to relevant medical 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.			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 Rehabilitation Medicine Services, relevant medical subspecialties services/units, consultants, medical practitioners and staff of the Rehabilitation Medicine Services.	NA				
	2.	Organisation chart of the service's 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				
17.1.1.3	The Governing Body shall ensure that Rehabilitation Medicine Services are organised in such a way as to: a) facilitate the provision of rehabilitation medicine 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 providing rehabilitation medicine services			NA			NA	

	d) ensure that all medical practitioners are involved in the formulation of policies and procedures concerning patient care appropriate to the scope of services of the Facility EVIDENCE OF COMPLIANCE 1. Departmental/Service operational policies that address items (a) to (d). — NA 2. Policies on patients' safety and patient and family rights. — NA 3. Medical Staff By-Laws — NA 4. Evidence of involvement of medical practitioners in the formulation of policies and procedures concerning patient care. — NA 5. Involvement of Head of the Service in the Medical and Dental Advisory Committee/Medical Advisory Committee and ward meetings. — NA 6. Communication between governing body/Head of Service and medical practitioners addressing requirement of service provision, e.g. minutes of meetings — NA 7. Proper and adequate equipment according to current standards. — NA 8. Patient discharge notes show evidence of follow up or referral to relevant agencies. — NA					
17.1.1.4	There is a mechanism to ensure effective interaction between the Rehabilitation Medicine Services and the Governing Body and Management 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 rehabilitation medicine specialist as the Head of Rehabilitation Medicine Services delineating his/her authority, responsibilities and accountabilities in a written document according to the relevant Acts to manage and control the Rehabilitation Medicine Services; b) Medical and Dental Advisory Committee (MDAC) to advise the Governing Body on issues related to clinical governance, i.e. planning, coordinating, implementation, control and to improve activities relating to Rehabilitation Medicine Services. EVIDENCE OF COMPLIANCE	NA			NA	

	1.	Letter of appointment and delineation of duties and responsibilities of the Head of Service.	NA				
	2.	Registration with National Specialist Register/Gazettement	NA				
	3.	Letter of appointment and Terms of Reference as member of the Medical and Dental Advisory Committee/Medical Advisory Committee.	NA				
	4.	Minutes of meetings of MDAC/Management	NA				
17.1.1.5	There is documented evidence of multidisciplinary, interdisciplinary or transdisciplinary team management of patients led by a Rehabilitation Medicine Specialist			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Minutes of interdisciplinary meetings	NA				
	2.	Communication memos/interdisciplinary clinical meetings evidenced	NA				
	3.	Sample patient's medical records	NA				
17.1.1.6 CORE	The Head of Rehabilitation Medicine 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/appointment of the Head of Service in committees and subcommittees where relevant, e.g. Procurement of Equipment Committee, Medical Records Committee, Hospital Infection and Antibiotic Control Committee, etc.	NA				
	2.	Minutes of meetings of committees	NA				
	3.	Minutes of meeting of Senior Management Team.	NA				
17.1.1.7	The Head of the Rehabilitation Medicine Services shall be involved for the following aspects of management of the Rehabilitation Medicine Services: a) the preparation of budget and ensuring that expenditure remains within the budget allocated;			NA			NA	

	b) human resource management and development; c) development of policies and procedures and ensuring compliance to them; d) facility and equipment management; e) safety and performance improvement activities and risk management. **EVIDENCE OF COMPLIANCE** 1. Minutes of meetings of Rehabilitation Medicine Services indicate the involvement of Head of Service on aspects of items (a) to (e). — NA 2. Attendance list of members with adequate quorum — NA 3. Minutes are accessible to all staff — NA 4. Endorsement of policies and procedures — NA 5. Request for allocation of budget and staffing — NA 6. Implementation of performance improvement activities — NA					
17.1.1.8	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 Rehabilitation Medicine 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	NA			NA	
17.1.1.9	Where there are medical practitioners in training, there is evidence that: a) their responsibilities for patient care are documented; b) their training needs are identified;	NA			NA	

	c) appropriate supervision and training are given to the medical practitioners concerned. EVIDENCE OF COMPLIANCE 1. Log books — NA 2. Assessment reports — NA 3. Training timetable, continuing medical education and attendances list. — NA						
17.1.1.10	Appropriate statistics and records shall be maintained in relation to the provision of Rehabilitation Medicine Services and used for managing the services and patient care purposes. EVIDENCE OF COMPLIANCE 1. Records are available but not limited to the following: a) workload/census for inpatients and outpatients; — NA b) annual report; — NA c) accident/incident reports; — NA d) staffing number and staff profile; — NA e) staff training records; — NA f) data on performance improvement activities, including performance indicators. — NA	NA			NA		

TOPIC TOPIC 17.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD STANDARD 17.2.1
The Rehabilitation Medicine Services shall be directed by a qualified and competent medical practitioner, and staffed by suitably qualified and competent clinical staff to achieve the goals and objectives of the Rehabilitation Medicine Services.

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
17.2.1.1	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) process for granting of clinical credentialing & privileging and re-privileging by authorized committee e) the period of time for which the privileges are to be granted is specified; f) current registration with the local professional registration bodies, e.g. Malaysian Medical Council, National Specialist Registry; g) peer recommendations are taken into account when privileges are being considered; h) the recommendations of the relevant department and/or major professional services for privileges to be granted are taken into consideration. EVIDENCE OF COMPLIANCE	NA			NA	

	1.	Documented policies and procedures are established to govern the credentialing and privileging processes which include items (a) to (g).	NA				
	2.	Compliance with policy and criteria for credentialing and privileging	NA				
	3.	Competency records/log books	NA				
	4.	Recommendations from peer/referee	NA				
	5.	Privileging certificates, Annual Practising Certificate (APC) and National Specialist Register (NSR) Certificates	NA				
	6.	Availability of the list of procedures requiring credentialing and privileging.	NA				
	7.	Availability of list of procedures to include core procedures specific to the disciplines performed by medical officers.	NA				
	8.	process of credentialing and privileging and re-privileging by authorised committee.	NA				
17.2.1.2 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				
17.2.1.3	Clinical staff perform within the privileges conferred.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Verification of procedures performed by individuals at point of care within the awarded privileging rights with evidence of:					
	a)	list of procedures privileged;	NA				
	b)	clinical notes.	NA				
17.2.1.4	There are written and dated 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;			NA			NA	

d) reviewed when required and when there is a major change in any of the following:
i) nature and scope of work;
ii) duties and responsibilities;
iii) general and specific accountabilities;
iv) qualifications required and privileges granted;
v) staffing patterns;
vi) Statutory Regulations.

e) administrative and clinical functions.

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

STANDARD STANDARD 17.2.2

STAFF TRAINING, EDUCATION, APPRAISAL AND RESEARCH

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

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

17.2.2.4	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. **EVIDENCE OF COMPLIANCE** 1. Training needs assessment is carried out and gaps identified. — NA 2. A staff development plan based on training needs assessment is available. — NA 3. Training schedule/calendar is in place. — NA 4. Training module — NA	NA			NA	
17.2.2.5	Staff including medical practitioners receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility. **EVIDENCE OF COMPLIANCE** 1. Performance appraisal for staff including medical practitioners is completed upon probationary period and as an annual exercise. — NA	NA			NA	
17.2.2.6	Where appropriate the Facility shall endeavour to undertake clinical research using available resources. **EVIDENCE OF COMPLIANCE** 1. Documented evidence of research activities e.g. protocol, policies, consent etc. — NA	NA			NA	

STANDARD STANDARD 17.2.3

STAFFING LEVEL AND STAFF COMPETENCY

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

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
17.2.3.1	Deployment of all service providers for the Rehabilitation Medicine 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 good clinical practice, addressing also the intensity of care provided for; • Rehabilitation Physician :1:16 patients • Medical Officers :1:8 patients • Nurses/Medical Assistants :1:4 patients(At least 1 post basic rehabilitation nurse available per shift) • Physiotherapist :1:6 patients • Occupational Therapists :1:6 patients • Speech Therapists :1:6 patients • Medical Social Worker :1:24 patients • Clinical Psychologist :1:24 patients • Healthcare Assistants :1:4 patients • Clerks :1 per ward; 1 per clinic 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 sickness; double shift duties by clinical staff is 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	NA			NA	

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 staff to be available on call;

f) dietetic and pharmacy service providers are available on site.

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

STANDARD STANDARD 17.2.4

STAFF ORIENTATION

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

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
17.2.4.1	There is a structured orientation programme for all newly appointed staff to the Rehabilitation Medicine Services including medical practitioners and for those new to specific areas that include the following: a) explanation of the goals, objectives, policies and procedures of the Facility and those of the Rehabilitation Medicine 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; 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 Rehabilitation Medicine Services; k) education on Patient and Family Rights; l) education on MSQH Standards requirements. m) grievance pathway for staff harassment. EVIDENCE OF COMPLIANCE	NA			NA	

	1.	Policy requiring all new staff to attend a structured orientation programme.	NA					
	2.	There is Rehabilitation Medicine Services orientation programme with relevant topics not limited to topics covered from (a) to (m).	NA					
	3.	Attendance list	NA					

TOPIC TOPIC 17.3
POLICIES AND PROCEDURES

STANDARD STANDARD 17.3.1
DEVELOPMENT, DERIVATION AND DOCUMENTATION
There are written and dated policies and procedures for all activities of the Rehabilitation Medicine Services. These policies and procedures reflect current standards of medical practice, relevant statutory requirements, and the purposes of the services. These policies and procedures, terms of reference, by-laws, rules or regulations, state how the clinical staff including medical practitioners regulate themselves and provide patient care.

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
17.3.1.1 CORE	There are written policies and procedures for the Rehabilitation Medicine 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	
17.3.1.2	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved. Cross departmental collaboration is practised in developing relevant policies and procedures where applicable. **EVIDENCE OF COMPLIANCE** 1. Minutes of committee meetings on development and revision on policies and procedures. — NA	NA			NA	

	2.	Minutes of meeting with evidence of cross reference with other departments	NA				
	3.	Documented cross departmental policies	NA				
17.3.1.3 CORE	The policy and procedure documentation shall cover at least the following topics and any others required by law: a) description of the organisational structure of the Rehabilitation Medicine Services; b) clinical practice guidelines; c) clinical documentation includes pain as the 5th vital sign where appropriate; d) handover communication; e) drug prescription, dispensing and administration; f) blood transfusion; g) continuing of care including regular review of patient, review of investigation results, discharge (planned or At Own Risk), referrals and escort as necessary; h) pain management; i) management of patients under police custody/prisoner; j) management of cases with infectious diseases including notification of notifiable diseases; k) the responsibilities of the staff including medical practitioners in relation to internal and external disasters are documented, and known to the staff (contingency plan); l) incident reports shall be compiled, investigated, discussed and recorded and action plans implemented; m) medical emergency, staff / patients safety as well as occupational safety and health are addressed; n) admission and discharge criteria is established;		NA			NA	

	o) end of life care; p) management of a death. **EVIDENCE OF COMPLIANCE** 1. Documented policies and procedures that address but not limited to items (a) to (p). — NA 2. Incident reports and actions taken as required. — NA 3. Policies on Code Blue, security response and Occupational Safety and Health Act with evidence of implementation process — NA					
17.3.1.4	The care process shows documentary evidence of goal planning that involves team members, patients and care givers. **EVIDENCE OF COMPLIANCE** 1. Samples of interdisciplinary records (IDR) documentation — NA 2. Samples of family conferences documentation — NA	NA			NA	
17.3.1.5	Care programmes incorporate the use of functional assessments at entry and completion of planned care programme. **EVIDENCE OF COMPLIANCE** 1. Samples of IDR documentation — NA 2. Samples of functional outcomes instrument used — NA	NA			NA	
17.3.1.6	Care providers, where required, need to provide appropriate and adequate communication to subsequent healthcare providers taking over the patient's care. **EVIDENCE OF COMPLIANCE** 1. Patient's medical records — NA 2. Discharge summary/referral letter — NA	NA			NA	
17.3.1.7	Evidence of facilitation of societal reintegration shall be available in the care process as shown by: a) assistive devices procurement; b) home assessment or visit documentation;	NA			NA	

	c) community placement; d) school/ worksite assessment or visit documentation e) school/employment placement; f) return to work program / clinic; g) disability certification as per PWDs registration guidelines by Department for Development of PWDs. **EVIDENCE OF COMPLIANCE** 1. Discharge summary — NA 2. IDR documentation — NA 3. Patient's clinical notes — NA 4. Sample referral letter with evidence of (a) to (e) — NA					
17.3.1.8	A programme shall be in place for the monitoring and continued training of patients and staff safety with regards to falls, transport/transfers and handling of patients. **EVIDENCE OF COMPLIANCE** 1. Records on training for patients and staffs addressing: a) falls; — NA b) transfer and handling of patients — NA	NA			NA	
17.3.1.9 CORE	A programme shall be in place for assessing, monitoring and measuring of improvement of inpatients undergoing active rehabilitation which includes the following: a) conduct of interdisciplinary team meeting within one week of inpatient admission; b) the use of functional assessment measures within seven (7) days of patients undergoing inpatient rehabilitation; c) the use of functional assessment measures before cessation of rehabilitation programme for patients undergoing inpatient rehabilitation for at least seven (7) days;	NA			NA	

	d) monitoring of patient and staff falls, occupational injuries and backache. EVIDENCE OF COMPLIANCE 1. Structured programme for inpatients undergoing active rehabilitation that include the aspects of (a) to (d) — NA 2. Discharge summary — NA 3. IDR documentation and patient's clinical notes — NA 4. Sample referral letter — NA 5. Incident reports on falls, injuries etc of patients and staff — NA 6. Sample of functional outcomes instrument used — NA					
17.3.1.10	Current policies and procedures are communicated to all staff EVIDENCE OF COMPLIANCE 1. Training and briefing on the current policies and procedures/Minutes of meetings — NA 2. Circulation list and acknowledgement — NA	NA			NA	
17.3.1.11 CORE	There is evidence of compliance with policies and procedures. EVIDENCE OF COMPLIANCE 1. Compliance with policies and procedures through: a) interview of staff on practices; — NA b) verify with observation on practices; — NA c) results of audit on practices; — NA d) practices in line with established policies and procedures. — NA	NA			NA	
17.3.1.12	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, ByLaws and statutory requirements are accessible to staff. 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	NA			NA	
17.3.1.13	The services shall operate on a 24-hour basis providing a level of care appropriate to the activity of the patients in the Facility.	NA			NA	

	EVIDENCE OF COMPLIANCE						
	1.	Operational policy on 24-hour services	NA				
	2.	Staffing level reflects good mix of experienced staff and the intensity of activities during each shift.	NA				
	3.	24-hour duty roster	NA				
	4.	On-call roster is dated and authorised.	NA				

TOPIC TOPIC 17.4
FACILITIES AND EQUIPMENT

STANDARD STANDARD 17.4.1
The Head of Rehabilitation Medicine 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 Rehabilitation Medicine Services.

CRITERION NO.	CRITERIA FOR COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
17.4.1.1	There are adequate and appropriate facilities and equipment with proper utilisation of space to enable staff to carry out their professional, teaching and administrative functions.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Adequate and proper utilisation of space.	NA				
	2.	Appropriate type of equipment to match the complexity of services.	NA				
	3.	Adequate facilities and equipment at each patient care area for safe care. (e.g. defibrillators, emergency cart, hand washing facilities etc)	NA				
	4.	Easy access and clear exit routes	NA				
	5.	Absence of overcrowding	NA				
17.4.1.2	Existing facilities shall take cognizance of the safety of staff and patients.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Design and layout of the unit, e.g. wards, treatment rooms, dirty and clean utility rooms, access, lighting, signage, etc address the safety aspects of staff and patients.	NA				
	2.	Adequate equipment and supplies for Rehabilitation Medicine Services, e.g. emergency trolley, functioning patient call bell, adequate PPE etc.	NA				
	3.	Equipment should have scheduled planned preventive maintenance (PPM)	NA				
17.4.1.3	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 and functioning telecommunication modalities available for daily operation and during emergencies e.g. landlines, hand phones, pagers, intercom.	NA				
17.4.1.4	All medical devices procured after gazettement of Medical Device Act 2012 shall comply with the regulations of the Acts.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Availability of relevant document and certificates	NA				

STANDARD STANDARD 17.4.2
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
17.4.2.1	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 including disable friendly access environment	NA				
	2.	Feedback from patient satisfaction survey	NA				
	3.	Incident reporting relating to facilities if any	NA				
	4.	Disabled friendly parking facilities	NA				
17.4.2.2	Equipment, both for emergency and non-emergency usage, shall be appropriate to the level of care.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Availability of emergency and non-emergency equipment appropriate to level of care, such as defibrillator, emergency trolley, suction machine, electrocardiogram (ECG) machine, infusion or syringe pump, vital sign monitor, etc.	NA				
	2.	Scheduled checking of items in emergency trolley	NA				
17.4.2.3	The wards where inpatient rehabilitation care is undertaken shall be equipped with the following: a) beds are height adjustable, have removable cot sides, have single and/or double fowler position options with night light facility; b) nurse call system; c) pressure support system for care and protection of skin viability;		NA			NA	

	d) disabled friendly toilets with hand railings and baths/showers that have thermostat safety control over piped hot water, nurse call system for assistance and safety devices for prevention of falls including mechanical lifting equipment; e) appropriate assistive devices for facilitating independent ability and basic activities of daily living shall be available. These include wheelchairs, commodes, walking aids amongst others. f) ceiling mounted or mobile hoist for safe transfer EVIDENCE OF COMPLIANCE 1. Inpatient rehabilitation care facilities are appropriately equipped and include items listed (a) to (e). — NA					
17.4.2.4	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements. 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	NA			NA	
17.4.2.5 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. 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	NA			NA	
17.4.2.6	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment. EVIDENCE OF COMPLIANCE	NA			NA	

	1.	User training records	NA				
	2.	Competency assessment record	NA				
	3.	Letter of authorisation	NA				
	4.	List of staff trained and authorised to operate specialised equipment	NA				
17.4.2.7	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 in a planned and systematic manner.	NA				
	2.	Procurement of new technology where required is evidenced.	NA				
17.4.2.8	The physical rehabilitation activity facilities include: a) physiotherapy areas that incorporate adequate equipment and space for treatment, gait training, exercise and a heated hydrotherapy pool; b) provision for disable accessible toilets, lockers and shower facilities that have thermostat safety control over piped hot water; c) a general exercise area with flexible open space and at least one wall reinforced for installation of stall bars to be available; d) availability of at least one (1) sink of sufficient width and depth for wet packs. Installation of ceiling moorings to support at least 230 kgs located at specific treatment areas for attachment of overhead equipment.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Design of the physical rehabilitation activity facilities meets the standard requirements and includes the aspects of (a) to (d).	NA				
	2.	Presence of the required equipment for the relevant rehabilitation activities.	NA				
17.4.2.9	Occupational Therapy areas include space for upper limb function retraining, activities of daily living (ADL) training, work hardening, orthotic/pressure garment manufacture, cognition and perception training, pre-driving assessment, group activities and leisure activities.			NA			NA	

	EVIDENCE OF COMPLIANCE						
	1.	Presence of the required facilities and equipment for occupational therapy activities.	NA				

STANDARD STANDARD 17.4.3

FACILITIES FOR REHABILITATION MEDICINE OUTPATIENT SERVICES

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

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
17.4.3.1	The Specialist Outpatient Services shall have the following features: a) the organisation and management of the clinics are planned so as to ensure prompt attention to patients, minimal waiting time, and avoidance of unnecessary visits by the patients; b) record keeping shall be efficient; c) an appointment or queuing system is used to manage patient consultations; d) the clinic is easily accessible including for non-ambulant patient and is easily identified through adequate signage. There should be provision for disabled friendly parking bays; e) the clinic is located close to other facilities, e.g. radiology, laboratories and pharmacy; f) appropriate assistive amenities and devices for facilitating independent ability and basic activities of daily living shall be available which include ramps, hand railings, wheelchairs, commodes, walking aids, single fowler height adjustable examination couches amongst others; g) disabled friendly toilets, hand railings and taps that have thermostat safety control over piped hot water, nurse call system for assistance and safety devices for prevention of falls; h) adequate provision is made for patient comfort; i) storage space, including adequate space for stretcher and wheelchair; j) child assessment and therapy and play area facilities for children; k) rooms/facilities for speech and clinical psychology assessment;	NA			NA	

	l) resource centre for independent living equipment (preferably); m) independent living unit (preferable); n) sinks with hand washing facilities to be available in all treatment areas. **EVIDENCE OF COMPLIANCE** 1. The Specialist Outpatient Services address (a) to (n) 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) adequate patient personal use items, e.g. wheelchair, etc; NA i) adequate waiting area, rest rooms, refreshments, reading material and parking space. NA					
17.4.3.2	Adequate numbers of rooms are provided to ensure patient privacy and confidentiality for various patient care activities including: a) consultation (not more than one patient in a room at any time); b) conduct of minor procedures and nursing procedures; maintain a register of procedures performed; c) performance of various tests. **EVIDENCE OF COMPLIANCE** 1. Adequate facilities for consultation and patient care activities that address (a) to (c) with evidence of but not limited to the following: a) privacy of patient is ensured; NA b) procedure room appropriately equipped; NA c) patient monitoring device is available where required; NA	NA			NA	

	d)	list of procedures done.	NA					

TOPIC TOPIC 17.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD STANDARD 17.5.1
The Head of Rehabilitation Medicine Services shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Rehabilitation Medicine Services. The Head of Rehabilitation Medicine 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
17.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Rehabilitation Medicine Services. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated.	NA			NA	
	EVIDENCE OF COMPLIANCE					
	1. Planned performance improvement activities include (a) to (f — NA					
	2. Records on performance improvement activities — NA					
	3. Minutes of performance improvement meetings — NA					
	4. Performance improvement studies — NA					
	5. Records on innovation if available. — NA					
17.5.1.2	The Head of Rehabilitation Medicine 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				
17.5.1.3	The Head of the Rehabilitation Medicine 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				
17.5.1.4 CORE	The staff including medical practitioners provide an appropriate peer group structure for performing the safety and performance improvement activities to accomplish clinical care evaluation. a) The medical practitioners undertake clinical reviews of all risk assessments, incident reports, audits, safety and performance improvement activities: • i) as a single committee for all safety and performance improvement activities; • ii) in multidisciplinary committees within the Services;			NA			NA	

<table>
<tr><td></td><td>
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.

c) Clinical audit assessment is undertaken at least one (1) annually
<table>
<tr><th colspan="3">EVIDENCE OF COMPLIANCE</th></tr>
<tr><td>1.</td><td>Performance improvement activities</td><td>NA</td></tr>
<tr><td>2.</td><td>Minutes of meetings</td><td>NA</td></tr>
<tr><td>3.</td><td>Relevant reports and documents, e.g. clinical audit reports, incident reports, mortality and morbidity review reports, etc.</td><td>NA</td></tr>
</table>
</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>17.5.1.5
CORE</td><td>
There is tracking and trending of specific performance indicators not limited to but at least two (2) of the following:

a) Percentage of patients with waiting time of ≤ 60 minutes to see the doctor at the Rehabilitation Medicine Outpatient Clinic (Two or more registration areas involved)

b) Percentage of patients with waiting time of ≤ 90 minutes to see the doctor at the Rehabilitation Medicine Outpatient Clinic (Only one registration area involved)

c) Percentage of patients with established interdisciplinary rehabilitation plan within ≤ 5 working days of admission

d) Percentage of falls and near-falls in Rehabilitation Medicine Outpatient Clinic

e) percentage of inpatients with functional measure assessment upon admission and prior to cessation of patient rehabilitation programme (Target: >90%)
<table>
<tr><th colspan="3">EVIDENCE OF COMPLIANCE</th></tr>
<tr><td>1.</td><td>Specific performance indicators monitored.</td><td>NA</td></tr>
<tr><td>2.</td><td>Records on tracking and trending analysis.</td><td>NA</td></tr>
<tr><td>3.</td><td>Remedial measures taken where appropriate</td><td>NA</td></tr>
</table>
</td><td>NA</td><td></td><td></td><td>NA</td><td></td></tr>
<tr><td>17.5.1.6</td><td>Feedback on results of safety and performance improvement activities are regularly communicated to the staff.</td><td>NA</td><td></td><td></td><td>NA</td><td></td></tr>
</table>

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

TOPIC TOPIC 17.6
SPECIAL REQUIREMENTS

STANDARD STANDARD 17.6.1
SPINAL CORD INJURY
The provision of Spinal Cord Injury Care shall be organised and provided as inpatient care services. The facility shall be equipped, operated and maintained in a manner that ensures patients are effectively cared for taking into consideration the safety of the patients, and staff in accordance to relevant regulatory requirements.

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
17.6.1.1	ORGANISATION OF SPINAL CORD INJURY CARE The provision of Spinal Cord Injury Care shall be organised and managed through the following: a) a model of care of management is available; b) provision of Interdisciplinary Care involving Rehabilitation Medicine Physician, Nursing, Physiotherapy, Occupational Therapy, Medical Social Worker and Counsellors; c) consultation services from Urology, Plastic Surgery, Orthopaedics, Neurosurgery, Obstetrics and Gynaecology, Reproductive Medicine, Orthotic service is available or accessible; d) care plans are individualised, planned, monitored and evaluated; e) interdisciplinary records (IDR) and family conferences are an integral part of inpatient rehabilitation; f) patient assessment, functional and clinical status are measured at admission and upon discharge utilising at least the following : ASIA Neurological Assessment, Spinal Cord Independence Measure (SCIM), Modified Barthel Index (MBI); g) credentialing and privileging processes of the providers are established; h) allied Health staff must undergo at least three months of supervised work/training before undertaking unsupervised responsibilities; i) a registry of rehabilitated spinal cord injury patients will be maintained.	NA			NA	

	EVIDENCE OF COMPLIANCE						
	1.	Evidence of availability of model of care document and compliance to the care plan instituted	NA				
	2.	Clinical and IDR documentation	NA				
	3.	Provision of information on accessibility of referral services	NA				
	4.	Evidence of relevant documents/ certifications	NA				
	5.	Evidence of registry of rehabilitated Spinal Cord Injury (SCI) patients	NA				
17.6.1.2	STAFFING REQUIREMENTS a) The minimum number of staff for Level 4 Spinal Cord Injury Rehabilitation Service shall be as per rehabilitation standards except for: • Rehabilitation Physician :1:16 patients • Medical Officers :1:8 patients • Nurses/Medical Assistants :1:4 patients (At least 1 post basic rehabilitation trained nurse available per shift) Physiotherapist :1:6 patients • Occupational Therapists :1:6 patients • Speech Therapists :1:16 patients • Medical Social Worker :1:24 patients • Clinical Psychologist :1:24 patients • Healthcare Assistants :1:4 patients • Clerks :1 per ward;1 per clinic b) The Rehabilitation Medicine Physician heading the Spinal Injury Care Rehabilitation team shall preferably have special interest / subspecialty training in Spinal Cord Injury Rehabilitation. c) The therapist in the IDR team shall have undergone special interest training in Spinal Cord Injury rehabilitation of at least 3 months before undertaking unsupervised work. d) A case manager is available for each case			NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Evidence of staff positions filled as per requirement	NA				

	2.	Certification of relevant training of Rehabilitation Medicine Physician/therapists and other staff where applicable	NA				
	3.	Evidence of a case manager for each case	NA				
	4.	IDR documentation	NA				
	5.	Patient's Clinical notes	NA				
	6.	Workload Census	NA				
17.6.1.3	FACILITIES AND EQUIPMENT FOR SPINAL CORD INJURY (SCI) CARE There are adequate and appropriate facilities and equipment for provision of SCI care that include: a) preferably a Rehabilitation park for outdoor therapy; b) ward unit preferably be air conditioned; c) automated turning beds for pressure relief. d) hoist for safe transfer e) specialised wheelchairs – recliner, DAF, lightweight, motorized f) shower trolley or reclining commode wheelchair g) tilt table h) parallel bar i) various types of gait aids			NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Appropriate and adequate facilities and equipment that include (a) and (e)	NA				
17.6.1.4	PERFORMANCE IMPROVEMENT Performance improvement activities include the following: a) measurement of generic functional outcome measure at initial contact and prior to rehabilitation discharge – Modified Barthel Index (MBI);			NA			NA	

	b) measurement of disease specific functional outcome measure at initial contact and prior to rehabilitation discharge - Spinal Cord Injury Independence Measure (SCIM)						
	EVIDENCE OF COMPLIANCE						
	1.	Records on performance improvement that include (a) and (b) as evidenced upon inspection of:					
	a)	IDR Documentation	NA				
	b)	Patient's Clinical Notes	NA				

STANDARD STANDARD 17.6.2

STROKE

The provision of Stroke Care shall be organised and provided as inpatient or outpatient care services. The facility shall be equipped, operated and maintained in a manner that ensures patients are effectively cared for taking into consideration the safety of the patients, and staff in accordance to relevant regulatory requirements.

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
17.6.2.1	ORGANISATION OF STROKE CARE The provision of Stroke Care shall be organised and managed through the following: a) a model of care of management is available; b) functional and clinical measures incorporate at least the following: National Institute of Health Stroke Scale (NIHSS), Mini Mental State Examination (MMSE), Montreal Cognitive Assessment (MoCA), Modified Barthel Index (MBI), Motor Assessment Scale (MAS) Collaborative Dysphagia Audit (CODA)Guideline; c) consultation services from Neurologist, Neurosurgery, Geriatric, General Surgery, and Orthotic services are available or accessible; d) credentialing and privileging processes are established; e) a registry of rehabilitated stroke patients will shall be maintained.	NA			NA	
	EVIDENCE OF COMPLIANCE					
	1. Evidence of availability of model of care document and compliance to the care plan instituted — NA					
	2. Clinical and IDR documentation — NA					
	3. Provision of information on accessibility of referral services — NA					
	4. Evidence of relevant documents/certifications — NA					
	5. Evidence of registry of rehabilitated stroke patients — NA					
17.6.2.2	STAFFING REQUIREMENTS a) The minimum number of staff for a Level 4 Stroke Rehabilitation Services shall be as per rehabilitation standards.	NA			NA	

	b) The Rehabilitation Medicine Physician heading the Stroke Rehabilitation Team shall preferably have special interest / subspecialty training in Stroke Rehabilitation. c) The therapist in the IDR team shall have undergone special interest training in Stroke rehabilitation of at least three (3) months before undertaking unsupervised work. d) A case manager is available for each case. e) Allied health staff must undergo at least three (3) months of supervised work/training before undertaking unsupervised responsibilities. **EVIDENCE OF COMPLIANCE** 1. Evidence of staff positions filled as per requirement — NA 2. Certification of relevant training of Rehabilitation Medicine Physician/therapists and other staff where applicable. — NA 3. Evidence of a case manager for each case — NA 4. IDR documentation — NA 5. Patient's Clinical notes — NA 6. Workload Census — NA					
17.6.2.3	FACILITIES AND EQUIPMENT FOR STROKE REHABILITATION SERVICES There are adequate and appropriate facilities and equipment for provision of Stroke Rehabilitation Services that include: a) Space and equipment that incorporate the following: • i) Geriatric chairs with high back rest, arm and foot rest supports, and a table top. • ii) Specialised wheelchair – recliner, DAF • iii) Commode chair/wheelchair • iv) Tilt table • v) Parallel bar • vi) Various types of gait aids • vii) Hoist for safe transfer	NA			NA	

	EVIDENCE OF COMPLIANCE						
	1.	Appropriate and adequate facilities and equipment that include but not limited to (a).	NA				
17.6.2.4	PERFORMANCE IMPROVEMENT Performance improvement activities include the following: a) Measurement of generic functional outcome measure at initial contact and upon rehabilitation discharge– Modified Barthel Index (MBI) b) Measurement of disease specific functional outcome measure at initial contact and upon rehabilitation discharge – Motor Assessment Scale (MAS)			NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Records on performance improvement that include (a) and (b) as evidenced upon inspection of:					
	a)	IDR Documentation	NA				
	b)	Patient's Clinical Notes	NA				

SERVICE SUMMARY	
-	
OVERALL RATING :	NA
OVERALL RISK :	-