SERVICE STANDARD 01: GOVERNANCE, LEADERSHIP AND DIRECTION

PREAMBLE

Each Facility shall have a body ultimately responsible for all aspects of the Facility's operations. This is commonly called the Board of Directors/Facility Management or another similar name. For the purposes of these Standards, this group shall be called "The Governing Body." The Governing Body may delegate its duties and functions to the Person In Charge (PIC) of the Facility, who shall be responsible for the organization, management, and control of the Healthcare Facility and services.
For private healthcare facilities, a license or registration is required, which relates to the services.
For public hospitals where Cluster Services are provided, the services shall be reflected in the Lead and Non-Lead organization chart.

TOPIC 1.1

ORGANISATION AND MANAGEMENT

STANDARD 1.1.1

The Governing Body shall adopt a governing framework that constitutes the interl legislation that will meet the particular needs and complexities of the magement of the Facility and the range of services. These may be called Facility Operatiol Policies and Medical Staff By-Laws, which include Rules and Regulations, Terms of Reference, Policies, Resolutions or other similar terms and they shall govern the actions of the Board and Magement of the Facility. The governing framework is essential for the governce of the Facility.

CRITERION NO.	CRITERIA FOR COMPLIANCE			SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
1.1.1.1	The Governing Body shall ensure that the Vision, Mission and values statements, goals and operatiol plan objectives are identified, clearly documented and measurable; and measure the progress towards achieving the objectives as this reflect the Facility's roles and aspirations in the community that it serves. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	Vision, Mission and values statements, goals, and objectives of the Facility are available; endorsed and dated by the Governing Body.	4					
	2.	Evidence of planned reviews of the above statements.	4					
	3.	These statements are communicated to all staff (orientation programme, minutes of meeting, etc).	4					
	4.	Achievement of goals and objectives are monitored, reviewed, and revised accordingly.	3					

	5.	Cluster Management Committee shall have their own vision and mission specifying their service areas/disciplines	3				
1.1.1.2	The Governing Body shall ensure that in defining the roles of the Facility, the needs of the community to be served and their involvement are addressed and shall include policies and procedures on Patient and Family Rights with input from the Board of Visitors.		4			4	
	EVIDENCE OF COMPLIANCE						
	1.	Board of Visitors	3				
	2.	Policy on Patient and Family Rights	4				
	3.	Patient's charter	4				
1.1.1.3 CORE	The Governing Body shall adopt a governing framework in accordance with statutory and other legal requirements.		4			4	
	EVIDENCE OF COMPLIANCE						
	1.	License to operate (Private Healthcare Facility)/Gazettement letters and supporting documents (Public Healthcare Facility)	4				
	2.	Appointment of full time Person In Charge (PIC) in accordance with the Third Schedule in Private Healthcare Facilities and Services Act 1998 and Regulations 2006.	4				
	3.	Facility Operational Policies	4				
	4.	Medical Staff By-Laws or equivalent	4				
	5.	Medical Staff By-Laws or equivalent to address the disciplines under Cluster Services (where applicable)	4				
1.1.1.4 CORE	The governing framework shall include the following elements, unless otherwise provided for by statute: a) the Facility shall have a plan of organisation which includes an organisation chart that: i) provides a clear representation of the structure, functions and reporting relationships of the services; ii) is accessible to all staff; iii) is revised when there is a major change in organisation plan, functions, reporting relationships, goals and objectives and staffing patterns. iv) shall be exhibited in a conspicuous part of the Facility. b) appointment of members of the Governing Body, its officers including Person In Charge (PIC), and committees, any qualifications required of the incumbents, and		4			4	

	the terms of office; shall be done according to the relevant Acts, Regulations and By-Laws. Authority and duties of the Governing Body, its officers and committees are documented. c) shall indicate relationship of the Governing Body, Person In Charge, other executive staff and show the structure of reporting relationship of the services, medical practitioners, nursing and all other allied healthcare professiols. d) review of the governing framework at regular intervals and the governing framework is accessible to staff of the Facility.						
	EVIDENCE OF COMPLIANCE						
	1.	Current organisation chart of the Facility endorsed by the Governing Body which comply with (a)(i) to (iv).	4				
	2.	Appointment letters of members of the Governing Body, its officers, and committees	4				
	3.	Job descriptions	4				
	4.	Terms of Office/Tenure of officers	4				
	5.	Terms of Reference of committees	4				
	6.	Minutes of Facility-wide Management Committee meetings	4				
	7.	Minutes of Board meetings	4				
	8.	Evidence of review of the following documents (at least once every three years or earlier if needed)					
	a)	Facility-wide Operational Policies	4				
	b)	Departmental/Service Operational Policies	4				
	c)	Medical Staff By-Laws	4				
	d)	Terms of Reference of committees	4				
	e)	Cluster Service to be reflected in the organisation structure (where applicable)	4				
	f)	Above documents are made accessible to all staff.(hard or soft copies)	4				
1.1.1.5	The Governing Body shall make provision for the establishment and delineation of the purpose and function of any auxiliary organisations, such as St. John's Ambulance, Red Crescent, Angkatan Pertahanan Awam (APM) and others.			4			4	
	EVIDENCE OF COMPLIANCE						

	1.	Memorandum of Understanding and Terms of Reference with voluntary/auxiliary organisations.	4					

STANDARD 1.1.2

There shall be an appointment of the Person In Charge (PIC) who shall be a person possessing such qualification, training and experience as prescribed according to the relevant Acts, Regulations and By-Laws. The Person In Charge (PIC) shall be responsible for the organisation, magement and control of the Healthcare Facility or services to which a license or registration relates and shall answer to the Governing Body. Clinical staff appointments, credentialing and privileging shall be documented. These shall meet the requirements of the relevant Acts, Regulations and By-Laws.
There shall be a Medical and Dental Advisory Committee to advise the Governing Body to plan, coordite, implement, control and improve activities relating to clinical patient care.

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
1.1.2.1	The Person In Charge (PIC) shall hold a degree in medicine, registered with Malaysian Medical Council and has appropriate training and experience in accordance with the Third Schedule in the Private Healthcare Facilities and Services Act 1998 and Regulations 2006. EVIDENCE OF COMPLIANCE 1. Appointment letter of PIC/Hospital Director — 4 2. Job description of PIC/Hospital Director — 4	4			4	
1.1.2.2	The Person In Charge (PIC) shall hold a degree in medicine, registered with Malaysian Medical Council and has appropriate training and experience in accordance with the Third Schedule in the Private Healthcare Facilities and Services Act 1998 and Regulations 2006. EVIDENCE OF COMPLIANCE 1. Resume of PIC/Hospital Director — 4 2. Letter of appointment — 4	4			4	
1.1.2.3	The authority, responsibilities and accountabilities of the Person In Charge (PIC) are clearly delineated and documented in a letter of appointment. EVIDENCE OF COMPLIANCE 1. Letter of appointment of PIC/Hospital Director by the Chairman of the Governing body (BOM or BOD) — 4 2. Job description — 4	4			4	
1.1.2.4	The Person In Charge (PIC) shall be responsible to establish an organisational structure that clearly represents the uniformity of the clinical services and reporting relationships.	4			4	

	Where there are two or more registered medical practitioners/dental practitioners in any one specialty in the Facility, separate designated heads and functional units/services to be established for effective delivery of clinical services. **EVIDENCE OF COMPLIANCE** 1. The Facility's organisation chart showing the uniformity and reporting relationships of the clinical services. 4 2. Organisation charts of clinical services by departments/functional units with clear evidence of line of reporting. 4 3. Agenda and minutes of meetings of department/functional units shall be approved by the HOD. 4						
1.1.2.5	The Governing Body through the Person In Charge shall establish the following policies and procedures for medical practitioners: a) appointment; b) reappointment; c) delineation of clinical privileges, roles and responsibilities. **EVIDENCE OF COMPLIANCE** 1. Policies and procedures on: a) Credentialing and privileging 4 b) Appointment and reappointment 4 2. Minutes of Credentialing and Privileging Committee 4 3. Certified privileging certificates (with serial number) 4 4. Roles and responsibilities for medical practitioners/consultants 4		4			4	
1.1.2.6 CORE	The licensee of the Facility shall establish a Medical and Dental Advisory Committee (MDAC) whose members shall be registered medical and dental practitioners representing all medical and dental practitioners practising in the Facility and shall advise the Governing Body and Person In Charge (PIC) on all aspects relating to medical and dental practices. In the smaller public facilities, the Medical Staff/Clinical Staff Committee functions as the MDAC. The MDAC is expected to discharge its duties and responsibilities through subcommittees. **EVIDENCE OF COMPLIANCE** 1. Establishment of MDAC/MAC 4 2. Appointment letter of members of MDAC/MAC 4		4			4	

	3.	Terms of Reference of MDAC/MAC	4					
	4.	Minutes of meetings	4					
1.1.2.7	The MDAC and/or its subcommittees shall address at least the following areas of concern: a) development and consensus of policies, procedures and standards of patient care evidence based guidelines; b) credentialing and privileging of clinical care providers; c) maintenance of professional standards and ethics; d) safety and performance improvement activities and risk management framework which shall include both reactive and proactive measure; e) clinical documentation and medical records; f) prevention and control of infection and antibiotic usage; g) drug utilisation and medication practices; h) use of blood and blood products; i) continuing professional development, training and continuing medical education; j) facilitation and supervision of research including the ethical aspects of research where appropriate.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	List of standing agenda (if no subcommittees) / subcommittees to address (a) to (j)	4					
	2.	Membership of subcommittees (if applicable 2 - 5)	4					
	3.	Appointment letter of members of subcommittees	4					
	4.	Terms of Reference of subcommittees	4					
	5.	Minutes of meetings of subcommittees	4					
1.1.2.8	The Management Committee or its equivalent shall meet with sufficient regularity and with an adequate quorum. Minutes shall be kept and accessible to members. Findings, decisions and resolutions made during meetings shall be communicated to relevant staff members of the Facility and to the Governing Body.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	List of members of Management Committee and subcommittees	4					
	2.	Evidence that Management Committee members represent the various respective departments	4					
	3.	Letter of appointment	4					
	4.	Terms of Reference	4					

	5.	Minutes of meetings of Management Committee and subcommittees (where applicable)	4					

STANDARD 1.1.3

Service planning is based on the organisation's strategic direction and due consideration of financial factors and the external environment. The financial management of the Facility shall be organised to allow reasonable financial reports to be generated.

CRITERION NO.	CRITERIA FOR COMPLIANCE			SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
1.1.3.1	The Governing Body through the Person In Charge (PIC) and Management Team is responsible for the efficient management of the financial resources of the Facility.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	Financial management reflected in job descriptions of PIC and Management Team (Heads of Services)	4					
	2.	Designated Finance/Account Officer	4					
	3.	Minutes of financial and management meeting	4					
	4.	Financial management report	4					
	5.	Auditor's report (internal and external)	4					
	6.	Annual budget report	4					
1.1.3.2	An external audit is carried out by an appropriately qualified independent auditor at least on an annual basis and is reported to the Governing Body or its representative.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	Credentials of the external auditor	4					
	2.	External auditor's report	4					
1.1.3.3	The Governing Body or its representative (Board of Management) regularly reviews audit reports; and action is taken on any recommendations made by the auditor.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	Financial management reports	4					
	2.	Minutes of Governing Body or Board of Management	4					
	3.	Actions taken on auditor's recommendations.	4					
1.1.3.4	There is an appropriate programme of internal financial control.			4			4	

	EVIDENCE OF COMPLIANCE						
	1.	Financial Standard Operating Procedures or Treasury Instruction/Circular	4				
	2.	System for internal financial control	4				
1.1.3.5	An internal accounting system, which produces information reflecting the fiscal experience and the current financial position of the Facility, is maintained.			4			4	
	EVIDENCE OF COMPLIANCE						
	1.	Internal accounting system	4				
	2.	Current financial report	4				
1.1.3.6	There are written policies and procedures for all accounting functions			4			4	
	EVIDENCE OF COMPLIANCE						
	1.	Documented policies and procedures for all accounting functions.	4				
1.1.3.7	There is an appropriate and effective system of inventory and stock control			4			4	
	EVIDENCE OF COMPLIANCE						
	1.	System for inventory :					
	a)	Stock taking	4				
	b)	Registry of inventory	4				
	c)	Stock cards	4				
	2.	Receipt and distribution of assets	4				
	3.	Disposal of assets	4				
1.1.3.8	A budget is developed with the participation of appropriate staff. Periodic reports showing the relationship between the budget and actual expenditure shall be produced and analysed.			4			4	
	EVIDENCE OF COMPLIANCE						
	1.	Mechanism for budget preparation	4				
	2.	Budget Proposals	4				
	3.	Capital expenditure (CAPEX) or Operational expenditure (OPEX)	4				
	4.	Budget monitoring report (Analysis on budget versus expenditure)	4				

1.1.3.9	There is provision of comprehensive financial management reports to the Governing Body and periodic review as to the accuracy and appropriateness of these reports. **EVIDENCE OF COMPLIANCE** 1. Financial report to Board of Management/Board of Directors (Private Healthcare Facility) — 4 2. Financial report to Management (Public Healthcare Facility) — 4 3. Internal and external auditor's reports — 4		4			4	
1.1.3.10	There is an insurance programme for the protection of the buildings, contents, and other physical assets b) the protection of the financial assets c) professional liability to protect the Facility in respect of the professional actions of medical practitioners, paramedics and other support services staff. **EVIDENCE OF COMPLIANCE** 1. Insurance policy certificate with details on covers for (a) to (c). — 4		4			4	
1.1.3.11	The Governing Body shall establish an integrated information and communication strategy, structure and system that include the following: a) Organisational structure clearly shows line communication, interaction and decision making. b) Policies and procedures clearly allow data and information gathering and knowledge sharing within department, inter departmental and whole facility as well as with outside organization (where relevant) **EVIDENCE OF COMPLIANCE** 1. Organisational chart especially showing clear clinical line of communication, interaction and decision making — 4 2. Clinical policies and procedures — 4 3. Patients records management system including completeness and quality of content of medical record — 4 4. Information and communication technologies and tools example : PABX, Pagers, Phones, Social Media, etc. — 4		4			4	

STANDARD 1.1.4

The Governing Body shall ensure that all reasonable action is taken to conform to all applicable government Statutes, Acts, Regulations, By-Laws, Ordinances and Orders; and shall treat all information relating to the affairs of the Facility, patients and staff in a confidential manner.

CRITERION NO.	CRITERIA FOR COMPLIANCE			SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
1.1.4.1	The Governing Body shall ensure that all reasonable action is taken to conform to all applicable government Statutes, Acts, Regulations, By-Laws, Ordinances and Orders.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	Copies of all relevant Acts, Regulations, By-Laws, Ordinances and Orders related to the services are available and accessible to staff.	4					
	2.	Certificate of fitness of buildings, facilities and other physical assets.	4					
	3.	Reprimands/summons from Health Authorities and Fire Authority where applicable.	4					
	4.	Incident reporting related to non-conformance to relevant Acts and Regulations if any.	4					
1.1.4.2	The Governing Body and staff shall treat all information relating to the affairs of the Facility, patients and staff in a confidential manner.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	Policy on disclosure of information relating to the affairs of the Facility.	4					
	2.	Policy statements regarding release of patient information.	4					
	3.	Documented evidence of undertaking on confidentiality by staff.	4					
	4.	Compliance with Personal Data Protection Act (PDPA), Medical Records Guidelines from Ministry of Health and Malaysian Medical Council.	4					

STANDARD 1.1.5

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.

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<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>1.1.5.1
CORE</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; — 4
b) system for quality control of outsourced services (visit to off- site services, recognised certification); — 4
c) procedures for managing shortfall in service; — 4
d) Involvement in performance measurement of the relevant services provided to the Healthcare Facility. — 4</td><td>4</td><td></td><td></td><td>4</td><td></td></tr>
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TOPIC 1.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD 1.2.1
The Governing Body shall make adequate provision for the delegation of authority to the Person In Charge to ensure the achievement of the Facility's Vision, Mission, values, goals and objectives.

CRITERION NO.	CRITERIA FOR COMPLIANCE			SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
1.2.1.1	The Person In Charge (PIC) acts in accordance with the policies, delegated authority, and instructions of the Governing Body; and is responsible for the organisation, management and control of the Facility.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	Authorisation of all policies within the Facility	4					
	2.	Chairing of Credentialing and Privileging Committee	4					
	3.	Establish Continuing Medical Education (CME) Committee	4					
	4.	Establish/conduct Professional and Disciplinary Committee meetings	4					
	5.	Notes: For Cluster Services:						
	a)	Chairing of Credentialing and privileging by Cluster"	4					
	b)	Establish CME by Cluster Committee	4					
	c)	Conferment of Privileging Rights to be done by relevant authorities, CMC and PIC	4					
1.2.1.2	The Person In Charge (PIC) shall attend all meetings of the Governing Body.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	Attendance of PIC in minutes of meetings of Governing Body.	4					
1.2.1.3	The performance of the Person In Charge (PIC) shall be regularly reviewed by the Governing Body.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	Documented performance appraisal of PIC by the Board of Management	4					

STANDARD 1.2.2

APPOINTMENT, VERIFICATION OF CREDENTIALS AND PRIVILEGING

The appointment, reappointment and clinical privileges of medical practitioners, nursing and other healthcare professionals to the Healthcare Facility are appropriate to the complexity of services of the Facility.

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
1.2.2.1 CORE	The appointments of staff are made by the Governing Body or any delegated authority. For the medical practitioners, the Governing Body shall seek the advice of the Credentialing and Privileging Committee. The membership of the Credentialing and Privileging Committee may include representatives of the Governing Body and regional representation of medical practitioners. The committee meets regularly to make recommendations on the appointment, reappointment, and clinical privileges of each member of the staff of the facilities. EVIDENCE OF COMPLIANCE 1. Appointment and reappointment policy according to services listed in the hospital license — 4 2. Credentialing and privileging policies — 4 3. Minutes of meeting of Credentialing and Privileging Committee — 4 4. Evidence of compliance to procedure privileged to do against areas eg OT list for the said medical practitioner. — 4	4			4	
1.2.2.2	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: 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. EVIDENCE OF COMPLIANCE	4			4	

	1.	Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (d).	4					
	2.	Job description includes specialisation skills	4					
	3.	Relevant privileges granted where applicable	4					
	4.	The job description is acknowledged by the staff and signed by the Head of Service and dated.	4					
1.2.2.3 CORE	The criteria and mechanism taken by the Facility in determining appointments and privileges shall adhere to the following: a) the written policies and procedures for Appointment, Credentialing and Privileging; b) the decisions made are objective, fair and impartial; c) reappointments and privileges shall each be granted for a specified period of time; d) when appropriate, temporary appointments and privileges may be granted for a limited period of time according to a policy approved by the Governing Body; e) appointments and privileges are allocated in such a way that each staff functions within a specified area of competence.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	Written policies and procedures for Appointment, Credentialing and Privileging.	4					
	2.	Credentialing and privileging criteria include items (b) to (e)	4					
1.2.2.4 CORE	Criteria for determining appointments and privileges are specified and uniformly applied to all applicants based on the following principles: a) the criteria are designed to ensure patients will receive safe and quality care; b) the criteria include evidence of current competence, relevant training and/or experience, and current registration with the local professional registration bodies, e.g. Malaysian Medical Council; other criteria may apply, e.g. the needs of the Facility; c) personal recommendations are taken into account when recommendations for individual appointments and privileges are being considered; d) the relevant department and/or major professional services shall be represented when recommendations for individual appointments and privileges are being considered.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	Minutes of meetings of Credentialing and Privileging Committee	4					
	2.	Criteria for privileging rights to include items (b) and (c).	4					
	3.	Recommendations from referee	4					

	4.	Presence of relevant Head of Service at award of privileging rights to the individual at Credentialing and Privileging Committee meeting.	4				
1.2.2.5	The process for determining appointments and granting clinical privileges shall include the following: a) the applicant's request; b) the verification of qualifications submitted by applicants; c) the verification that relevant staff members are registered with the relevant national registers (Malaysian Medical Council and other registers for example, Nursing Board Malaysia, Medical Assistants Board Malaysia etc.); d) where relevant the staff member has a valid annual practising certificate; e) the staff member is professionally qualified for the position held; f) the assignment of duties and privileges that matches the qualifications and experience thus ensuring that he/she is capable of carrying out the duties and privileges to be accorded; g) the resources available in the Facility support the duties and privileges.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	The process of granting clinical privileges shall include items (a) to (g).	4				
1.2.2.6	The Governing Body shall formally grant in writing the delineated clinical privileges to each member appointed based on the recommendations of the Credentialing and Privileging Committee.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	Certified privileging certificates	4				
1.2.2.7	Clinical privileges may be granted for a limited period. If so, there shall be a provision for reappointment of the staff and for review of clinical privileges taking into account the individual's professional performance, peer recommendations, and other parameters of current competence. Examples of activities include: a) participation in safety and performance improvement activities and measurement of performance outcomes; b) continuing medical education; c) maintenance of adequate medical records; d) appropriate code of conduct; e) health status. The mechanism allows for upgrading of privileges to be granted; as well as continuation or downgrading of existing privileges, as appropriate.			4			4	
	EVIDENCE OF COMPLIANCE							

	1.	The reappointment and renewal of clinical privileges shall consider items (a) to (e).	4					
	2.	Provision of upgrading and downgrading of privileges.	4					
1.2.2.8	There is an avenue for appeals when decisions on clinical privileges and appointments are adverse to the applicant. This mechanism provides for review of decisions when requested by the applicant. The final decision in all cases shall be taken by the Governing Body and within a fixed period of time.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	Appeal Policy on clinical privileges is available.	4					

STANDARD 1.2.3

The Person In Charge (PIC) shall ensure effective human resource management system is in place in order for the Facility to operate efficiently.

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
1.2.3.1 CORE	The Person In Charge (PIC) shall ensure that an adequate number of appropriately qualified staff are available to meet the needs of patient care. EVIDENCE OF COMPLIANCE 1. Staff master plan — 4 2. Staff patient ratio appropriate to level of care — 4 3. Duty roster — 4 4. Job description — 4 5. Policy and procedures on qualification verification — 4	4			4	
1.2.3.2	The Person In Charge (PIC) shall establish and maintain policies and practices for staff planning that support safe patient care. These policies are: a) written and available to all employees; b) reviewed periodically at least once in three years and revised as necessary with the date of the most recent review being incorporated; c) established to include a procedure for notifying employees of changes in the policies. EVIDENCE OF COMPLIANCE 1. Human Resource policies — 4 2. Employee Handbook — 4 3. Policies are updated, endorsed and dated. — 4 4. Changes in policies are notified to the staff. — 4	4			4	
1.2.3.3	The Person In Charge (PIC) shall maintain accurate, complete and confidential staff records. These shall include the following but not limited to: a) records on leave and sickness with documented evidence; b) results of recent staff appraisal; c) qualifications held; d) evidence of current registration; e) records on clinical placements; f) amendments to the employment contract;	4			4	

	g) records on continuing education and training; h) records on staff counselling sessions; i) records on disciplinary action.						
	EVIDENCE OF COMPLIANCE						
	1.	Staff personal records which include but not limited to items (a) to (i).	4				
	2.	Staff personal records are kept confidential	4				
1.2.3.4	Staff receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.			4			4	
	EVIDENCE OF COMPLIANCE						
	1.	Performance appraisal for staff is completed upon probationary period and as an annual exercise. Notes: The Cluster Service PIC are involved in their performance appraisal which will be based on letter of appointment and specifications of their roles and responsibilities namely Clinical Governance, staff training and competence assessment and provide service where applicable.	4				
1.2.3.5	There is evidence that staff are involved in the appraisal of their performance.			4			4	
	EVIDENCE OF COMPLIANCE						
	1.	Evidence of staff involvement in the appraisal of their performance. Notes: The Cluster Service PIC are involved in their performance appraisal which will be based on letter of appointment and specifications of their roles and responsibilities namely Clinical Governance, staff training and competence assessment and provide service where applicable.	4				
1.2.3.6 CORE	Avenues for processing and reporting suggestions and grievance are clearly described and made known to the staff.			4			4	
	EVIDENCE OF COMPLIANCE						
	1.	Staff satisfaction survey, suggestions and grievance reporting, and processing mechanisms are available.	4				
	2.	Evidence of actions taken	4				

STANDARD 1.2.4

The Governing Body through the Person In Charge (PIC) shall ensure that staff follow the professional ethics of their respective professional bodies.

CRITERION NO.	CRITERIA FOR COMPLIANCE			SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
1.2.4.1	The Person In Charge (PIC) shall put in place a mechanism for the consideration of ethical issues faced by the Facility and for implementation of the resulting policies in timely manner.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	Policies on ethical issues.	4					
	2.	Ethics Committee or any other committees where ethical issue is discussed.	4					
	3.	Minutes of meetings	4					

STANDARD 1.2.5

The Governing Body through the Person In Charge (PIC) shall ensure that there are continuing education, orientation and in-service programmes for its members and all the staff in order to improve their knowledge and skills, thereby improving the function of the individual service.

CRITERION NO.	CRITERIA FOR COMPLIANCE			SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
1.2.5.1	There is a planned orientation programme for newly appointed members of the Governing Body and Board of Visitors.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	Orientation programme for Governing Body and Board of Visitors	4					
	2.	Orientation module	4					
	3.	Attendance list	4					
1.2.5.2	There is a planned orientation programme for all categories of newly appointed staff including medical practitioners. This programme is appropriate to the size of the Facility and includes: a) information on the Vision, Mission and values statements, Goals and Objectives of the Facility; b) explanation of particular duties and functions, lines of authority, areas of responsibility, and methods of obtaining appropriate resource materials; c) explanation of the expected responses to internal events, e.g. fire safety and external disasters and other contingencies; d) information about safety procedures including universal/standard precautions; e) provision for the acquisition of necessary additional skills; f) explanation of the methods that will be used to evaluate staff performance.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	Policy requiring all new staff to attend a structured orientation programme.	4					
	2.	There is orientation programme with relevant topics not limited to topics covered from (a) to (f) and supported by an individual area/unit specific orientation checklist/programme.	4					
	3.	Attendance list	4					
1.2.5.3 CORE	There is a planned staff development programme which provides in-service and continuing education opportunities for all categories of staff. The			4			4	

	Person In Charge (PIC) whenever possible makes resources available to allow implementation of such programmes (This may be done in collaboration with other organisations).							
	EVIDENCE OF COMPLIANCE							
	1.	A facility-wide staff development plan is available, dated and reviewed based on training needs assessment.	4					
	2.	Minutes of Training Committee	4					
	3.	Training calendar	4					
	4.	Contents of training programmes shall include patient centric topics and business continuity plan	4					
	5.	Training records on continuing education activities are kept and maintained for each staff.	4					
	6.	Allocation of training budget	4					

STANDARD 1.2.6

Where the Facility has teaching responsibilities to provide for the educational needs of medical undergraduates, postgraduates, nurses, allied health and other health professionals, there is a formal written agreement stating the terms of reference and the requirements of the teaching needs.

CRITERION NO.	CRITERIA FOR COMPLIANCE			SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
1.2.6.1 CORE	There are written agreements which include the following: a) lines of communication; b) provision of appropriately qualified staff to provide clinical supervision; c) student activities should be fully supervised; d) the faculty staff participating in the teaching/training and patient care of all categories of students in the Facility are credentialed and privileged; e) mechanism for dealing with problems during the teaching/training period; f) meeting the appropriate Standards of Accreditation for that part of the teaching/training functions and patient care within the Facility; g) Indemnity.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	Memorandum of agreement to include items (a) to (g)	4					
	2.	Joint management committee	4					
	3.	Minutes of meetings	4					
	4.	Contracts where applicable (private institutions)	4					
	5.	Compliance with the Memorandum of Agreement/contract.	4					
1.2.6.2	Organisations should have policies and procedures for the: a) promotion of staff well-being b) resolution of workplace issues			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	The promotion of staff well-being may involve:						
	a)	procedures to promote well-being, e.g. stress management, workload monitoring, management of worklife balance, healthy lifestyle programmes eg. BookDoc, KOSPEN	4					
	b)	staff being provided with appropriate supervision, support and advice e.g. Mentor Mentee	4					
	2.	The resolution of workplace issues may involve:						

	a)	measures to protect staff against violence, bullying and harassment e.g. signage	4					
	b)	clear procedures for the effective management of underperformance eg feedback on Sasaran Kerja Tahunan (SKT)	4					

TOPIC 1.3
POLICIES AND PROCEDURES

STANDARD 1.3.1

The Governing Body through the Person In Charge (PIC) shall ensure that documented and dated policies and procedures in line with the requirements of the relevant regulations are available to guide all staff, including medical practitioners and locums, patients and visitors in respect of the operations of the Facility.

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
1.3.1.1 CORE	In determining policies and procedures, the Person In Charge (PIC) shall consider both external and internal factors relevant to the Facility and shall ensure that policies are: a) clearly articulated in understandable language; b) recorded in policy manuals; c) determined only on the basis of adequate information and consultation; d) able to guide those making decisions; e) capable of being implemented; f) relevant with current Acts, Regulations and By-Laws.	4			4	
	EVIDENCE OF COMPLIANCE					
	1. Facility-wide Operational Policies — 4 2. Medical Staff By-Laws — 4 3. Departmental policies and procedures — 4 4. Policies are relevant with current Acts, Regulations and By-Laws. Notes: The Cluster Service Policy shall be based on integrated care delivery where the patient care flow is ensured to be continuous and seamless throughout the patient care process from the non-lead to lead and vice versa. — 4					
1.3.1.2	The Person In Charge (PIC) shall ensure that the activities of the Facility are monitored and consistent with written policies.	4			4	
	EVIDENCE OF COMPLIANCE					
	1. Results of audits — 4 2. Reports on supervisory visits (24 hours nursing report) — 4 3. 24 hours Facility reports (Maintenance Department's report) — 4					

1.3.1.3 CORE	Policies and procedures are dated, authorised, signed and reviewed at least once every three years and revised as required and readily accessible for reference.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	Policies and procedures are updated, endorsed and dated.	4					
	2.	Evidence of periodic review	4					
1.3.1.4 CORE	Policies and procedures are widely communicated throughout the Facility.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	Circular or memos on new policies	4					
	2.	Training and briefing on the current policies and procedures/Minutes of meetings	4					
	3.	Circulation list and acknowledgement	4					
	4.	Audits on staff compliance	4					

TOPIC 1.4
FACILITIES AND EQUIPMENT

STANDARD 1.4.1
The Governing Body through the Person In Charge (PIC) has the overall responsibility for ensuring the provision of appropriate facilities and equipment so as to enable the achievement of the objectives of the Facility, in keeping with relevant Acts, Regulations and By-Laws.

CRITERION NO.	CRITERIA FOR COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
1.4.1.1	The Person In Charge ensure that facilities and equipment are adequate and safe for the level of services provided		4			4	
	EVIDENCE OF COMPLIANCE						
	1.	Adequate facilities and equipment at each patient care area for safe care.	4				
	2.	Appropriate type of equipment to match the complexity of services.	4				
	3.	Planned replacement of equipment based on life cycle reports.	4				
	4.	Planned refurbishment of the Facility/new facilities	4				
	5.	Provision for budget allocation	4				
	6.	Establishment of Procurement Committee	4				
1.4.1.2 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.		4			4	
	EVIDENCE OF COMPLIANCE						
	1.	Planned Preventive Maintenance records, such as schedule, stickers, etc.	4				
	2.	Planned Replacement Programme where applicable	4				
	3.	Complaint records	4				
	4.	Asset inventory	4				
1.4.1.3	There are planned upgrading and replacement programmes for facilities and equipment.		4			4	
	EVIDENCE OF COMPLIANCE						

	1.	Master plans for upgrading and replacement for facilities and equipment.	4					

TOPIC 1.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 1.5.1
The Governing Body through the Person In Charge (PIC) shall establish, implement and monitor Risk Management Programme with a systematic and effective safety and performance improvement plan throughout the Facility as required under the relevant Acts, Regulations and By-Laws.

CRITERION NO.	CRITERIA FOR COMPLIANCE			SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
1.5.1.1 CORE	The Risk Management Programme refers to planned and systematic safety and performance improvement activities that shall include but not limited to risk reduction activities such as Mortality and Morbidity Reviews, Incident Reporting and Grievance Mechanism.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	Establishment of Risk Management Program to include both clinical/non clinical	4					
	2.	Implementation and monitoring of risk assessment activities:-						
	a)	Risk Register;	4					
	b)	Risk assessment reports;	4					
	c)	Root Cause Analysis (RCA) report;	4					
	d)	action plans	4					
	e)	remedial measures;	4					
	f)	clinical audit including patient safety programmes (mortality and morbidity review, etc).	4					
	g)	Sentinel Events shall be investigated with appropriate corrective and preventive actions, and discussed by the governing body.	4					
1.5.1.2	There are clearly assigned responsibilities for safety and performance improvement activities within the services.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	Assigned officers	4					
	2.	Letter of appointment/assignment	4					

<table>
<tr><td>1.5.1.3</td><td>The Risk Management System addresses World Health Organization (WHO) Global Patient Safety Initiatives and Malaysian Patient Safety Goals.
a) World Health Organization (WHO) Global Patient Safety Challenges and Patient Safety Solutions (Appendix 1.a)
b) Malaysian Patient Safety Goals (Appendix 1.b).
The reporting system is through the "e-goals-patient safety" of the Ministry of Health, http://patientsafety.moh.gov.my/ as indicated in the Director General of Health,
Malaysia's circular (Ref: KKM/87/P3/10/8/0Jld 7(11).
<table><tr><th colspan="3">EVIDENCE OF COMPLIANCE</th></tr><tr><td>1.</td><td>Report on implementation of World Health Organization (WHO) Global Patient Safety Initiatives as indicated in the Appendix 1.a: World Health Organization (WHO) Global Patient Safety Initiatives</td><td>4</td></tr><tr><td>2.</td><td>Report on implementation of Malaysian Patient Safety Goals as indicated in the Appendix 1.b: Malaysian Patient Safety Goals 2.0 Guidelines</td><td>4</td></tr><tr><td>3.</td><td>WHO Global Surgery Initiative (GSI) implementation for non-lead hospitals providing Cluster Surgical Services where applicable.</td><td>4</td></tr></table></td><td>4</td><td></td><td></td><td>4</td><td></td></tr>
<tr><td>1.5.1.4
CORE</td><td>There is tracking and trending of the following specific performance indicators for the service:
a) percentage of patients leaving hospital against medical advice relative to all patients hospitalised within a specified period.
b) percentage of incidents/accidents during hospitalisation of patients as percentage of all admitted patients.
c) hospital wide patient satisfaction survey (six monthly basis)
d) In addition, healthcare facilities are required to monitor any other two (2) indicators with tracking and trending analysis to support its goals and objectives.
<table><tr><th colspan="3">EVIDENCE OF COMPLIANCE</th></tr><tr><td>1.</td><td>Specific performance indicators monitored.</td><td>4</td></tr><tr><td>2.</td><td>Records on tracking and trending analysis.</td><td>4</td></tr><tr><td>3.</td><td>Remedial measures taken where appropriate.</td><td>4</td></tr></table></td><td>4</td><td></td><td></td><td>4</td><td></td></tr>
<tr><td>1.5.1.5
CORE</td><td>Feedback on results of safety and performance improvement activities are regularly communicated to the staff, relevant authority and governing body. Results of safety and performance improvement activities are utilised for improvement of the organisation and management of the Facility.</td><td>4</td><td></td><td></td><td>4</td><td></td></tr>
</table>

	EVIDENCE OF COMPLIANCE						
	1.	Results on safety and performance improvement activities are accessible to staff.	4				
	2.	Evidence of feedback via communication on results of performance improvement activities e.g through continuing education activities/meetings.	4				
	3.	Minutes of service/unit/committee meetings/governance body	4				
	4.	Results of safety and performance improvement activities are utilised for improvement of the organisation and management of the Facility.	4				
1.5.1.6	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.		4			4	
	EVIDENCE OF COMPLIANCE						
	1.	Documentations on performance improvement activities and performance indicators.	4				
	2.	Policy statement on anonymity on patients and providers involved in performance improvement activities.	4				
1.5.1.7 CORE	There are safety and performance improvement activities that address patient/staff/service user safety.		4			4	
	EVIDENCE OF COMPLIANCE						
	1.	Staff health screening and medical check-up records.	4				
	2.	Identification of health risk factors, workload monitoring and stress management	4				
	3.	Infectious diseases prevention programme/activities	4				
	4.	Anti-smoking programme	4				
	5.	Healthy life style campaign activities:					
	a)	Stress management	NA				
	b)	Diet Programme	NA				
	6.	Staff training on:					
	a)	sharps and needle stick injury management;	4				
	b)	Occupational Safety and Health;	4				
	c)	ergonomics;	4				

	d)	biohazard waste disposal.	4					
	7.	Post exposure management	4					
	8.	Handling aggressive patients/visitors	4					
	9.	Universal/standard precautions	4					
	10.	Protection against bullying and harassment	NA					
	11.	Effective management of under performance	NA					
1.5.1.8	Facility performance data shall made publicly available			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	In the facility Annual Report	4					
	2.	In the facilities website or any other forms of publication	4					

SERVICE SUMMARY	
-	
OVERALL RATING :	NA
OVERALL RISK :	-