SERVICE STANDARD 02: ENVIRONMENTAL AND SAFETY SERVICES

PREAMBLE

The Person In Charge (PIC) shall ensure that the Facility is provided with a range of environmental and safety programmes throughout the Facility that address safety, comfort and conducive environment to reduce risks for patients, staff and visitors to the Facility. The programmes shall cover requirements for but not limited to hazard identification, fire safety, workplace safety, disaster plans (internal and external) hazardous material management and security services.

TOPIC 2.1
ORGANISATION AND MANAGEMENT

STANDARD 2.1.1

All activities related to Environmental and Safety Services shall be organised and administered by the Head of the Environmental and Safety Services and coordinated by appropriate Committees so as to provide optimum support to the goals, objectives and values of the Facility and to meet the needs of the Facility, patients, staff and visitors.

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
2.1.1.1 CORE	The Environmental and Safety Services shall address but not limited to the following: a) Environmental, Safety and Health b) Fire Safety c) Disaster Management i) External Disaster ii) Internal Disaster iii) Business Recovery Plan d) Hazardous Material and Recyclable Waste Management e) Security Services f) Vector and Pest Control EVIDENCE OF COMPLIANCE 1. Operational policies of the Environmental and Safety Services address activities (a) to (f). — 4	4			4	
2.1.1.2	The Person In Charge (PIC) shall appoint an appropriately qualified person as the Head of the Environmental and Safety Services, with clearly defined Terms of Reference, tenure, authority and responsibilities. EVIDENCE OF COMPLIANCE	3			3	

	1.	Person with appropriate qualification and experience appointed as Head of Environmental and Safety Services.	2				
	2.	Appointment/assignment letter with job description, roles and responsibilities	4				
2.1.1.3 CORE	The PIC shall designate various Committees to monitor, execute and manage various aspects of the Environment and Safety Services. The number of Committees shall be based on the complexity of the Facility. Each of the Committee shall have an appointed Chairperson as well as adequate number of appropriately qualified Committee members. Each Committee shall have clearly defined Terms of Reference, scope of activities, and tenure of membership.			4			4
	EVIDENCE OF COMPLIANCE						
	1.	The Committees have:					
	a)	Appointment of a Chairperson and Secretary	4				
	b)	Terms of Reference	4				
	c)	Committee members	4				
	d)	Tenure of membership	4				
	e)	Frequency of meetings	4				
	f)	Minutes of meetings	4				
2.1.1.4	Each designated Committee shall ensure that annual action plans have been prepared based on the Terms of Reference as well as the identified needs of the patients, visitors, staff, visiting medical practitioners and the outsourced service providers, and in compliance with relevant standards, guidelines and regulations. The action plans shall be reviewed annually and as required. Each revision shall be prepared, verified and approved by authorised personnel.			4			4
	EVIDENCE OF COMPLIANCE						
	1.	Approved yearly programme/action plan for each committee	4				
	2.	Revision of programme as required.	4				
	3.	Reports on implementation of yearly programme/action plan	4				
2.1.1.5 CORE	Management Committee shall oversee the structures of all ESH Committee and sub committees. Each Committee shall have an organisation chart that provides a clear representative on of the structure, functional and administrative relations with the relevant Departments/Units. The Committee organisation charts and individual			4			4

	organisation charts shall be approved by the PIC, and shall be accessible to all relevant Departments/Units. EVIDENCE OF COMPLIANCE 1. Approved Committee Organisation Charts — 4 2. Organisation charts of respective Committees that are: a) approved by the PIC; — 4 b) accessible to all relevant Departments/Unit. — 4					
2.1.1.6	Regular meetings are held between the respective appointed committee members to discuss issues and matters pertaining to the operations of the Environmental and Safety 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 of meetings of Committees are accessible, disseminated and acknowledged by the staff. — 4 2. Attendance list of members with adequate representatives of the service. — 4 3. Frequency of meetings as scheduled — 4 4. Discussions and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved). — 4	4			4	
2.1.1.7	There is clear evidence of coordination and cooperation amongst the various Committees pertaining to Environmental and Safety Services. Records on the coordination meetings and discussions as well as corrective and preventive actions taken shall be kept and made accessible to relevant staff when required. EVIDENCE OF COMPLIANCE 1. Minutes of meetings of the main Environmental and Safety Committee and coordination meetings. — 4 2. Records on corrective and preventive actions taken. — 4	4			4	
2.1.1.8	The Head of Environmental and Safety Services is involved in the planning, justification and management of the budget and resource utilisation for various activities of the services. EVIDENCE OF COMPLIANCE	4			4	

	1.	Minutes of Facility-wide management meeting	4				
	2.	Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service.	4				
	3.	Approved budget and resources	4				
2.1.1.9	Appropriate statistics and records shall be maintained in relation to the provision of Environmental and Safety Services and used for managing the services and patient care purposes.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	Records are available but not limited to the following:						
	a)	workload/census;	4					
	b)	annual report;	4					
	c)	accident/incident reports;	4					
	d)	staffing number and staff profile;	4					
	e)	staff training records (Fire Safety, Occupational Safety and Health, Disaster Plans, etc);	4					
	f)	data on performance improvement activities, including performance indicators.	4					
2.1.1.10	Where the entire Services or any part of the Services has been outsourced to any external service provider(s), the Head of the Environmental and Safety Services shall ensure that there is a written agreement between the external service provider and the Facility stating the requirements for goods and service delivery: a) formal lines of communication and responsibilities between the external service provider and the Facility; b) provision of adequate numbers of appropriately qualified personnel to perform their duties; c) participation, as appropriate, of the external service provider in the relevant Committees of the Facility; d) appropriate key performance indicators; e) arrangements for after-hours and emergency services; f) contingency plans for dealing with problems in service delivery; g) adequate facilities and equipment for providing the services; h) involvement of the external service provider in safety and performance improvement activities of the Facility, as appropriate; i) comply with the appropriate MSQH Standards of Accreditation for Environmental and Safety Services.			4			4	

	j) All incidents and accidents occur within the outsources services shall be report to ESH Committee. EVIDENCE OF COMPLIANCE 1. The Contract Agreement between the Facility and the external service provider(s) is in place and covers item (a) to (j). 4 2. Contractor's yearly performance appraisal 4 3. Fixed agenda for ESH sub committees to be discussed 4						

TOPIC 2.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD 2.2.1
The Head of Environmental and Safety Services shall ensure the designated Committees and relevant Units/Sections/Departments are provided with adequate numbers of appropriately qualified staff as required under relevant Acts, statutory regulations and standards to achieve the objectives of the services.

CRITERION NO.	CRITERIA FOR COMPLIANCE			SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
2.2.1.1 CORE	The Chairperson and the members of the various Committees are appropriately qualified, trained, experienced and/or certified to meet the objectives of the services.			4		Opportunities for Improvements: testing 1 2 3	3	
	EVIDENCE OF COMPLIANCE							
	1.	Certificates of qualification and registration of committee members.	4					
	2.	Attendance to relevant training, e.g. safety officer is registered with Department of Occupational Safety and Health (DOSH) and has attended National Institute of Occupational Safety and Health (NIOSH) training.	4					
	3.	Staff training records	4					
2.2.1.2	The authority, responsibilities and accountabilities of the Head of Environmental and Safety Services and the Chairpersons of various committees are clearly delineated and documented.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	Appointment/assignment letter for Head of Environmental and Safety Services and chairpersons of Committees.	4					
	2.	Terms of Reference	4					
2.2.1.3	Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the need of each committee and the Environmental and Safety Services.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	Number of personnel meet the work requirements or as per contract (where applicable)	4					

	2.	Qualifications of staff	4				
	3.	Organisation chart of Environmental and Safety Services	4				
2.2.1.4	There is a structured orientation programme where new staff and contractors are briefed on general operational policies and procedures of Environmental and Safety Services and relevant aspects of the Facility to prepare them for their roles and responsibilities.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	Policy requiring all new staff including outsourced service providers within the Facility to attend a structured orientation programme.	4				
	2.	Records on structured orientation programme	4				
	3.	Orientation Module	4				
	4.	List of attendance	4				
2.2.1.5	Continuing education activities are planned and provided to all staff on Environmental and Safety Services and other requirements specific to their areas of operations, including the use of appropriate personal protective equipment (PPE), safety measures in hazardous workplaces, i.e. operating rooms, obstetrical units, emergency services, special care units, isolation rooms, central sterilising supply services, kitchens, engineering workshops, laundry as well as environmental control in the prevention of healthcare associated infections, risk identification and compliance with relevant statutory regulations.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	Yearly training plan and programme for specific activities under the Environmental and Safety Services and additional training for hazardous workplaces.	4				
	2.	Training schedule and course contents	4				
	3.	List of attendance	4				
	4.	Certificate of attendance	4				

TOPIC 2.3
POLICIES AND PROCEDURES

STANDARD 2.3.1
The Head of Environmental and Safety Services shall ensure that there are appropriately documented policies and procedures, which shall reflect the current knowledge and practice under the Environmental and Safety Services, and these are in compliance with relevant standards and statutory requirements.

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
2.3.1.1 CORE	The Facility has a written Environmental, Health and Safety Policy statement that is displayed throughout the Facility. Other specific policies and procedures shall support and be consistent with the Environmental, Health and Safety Policy statement. 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.	4			4	
	EVIDENCE OF COMPLIANCE					
	1. Written, signed and dated Environmental, Health and Safety Policy. — 4					
	2. The Policy statement poster is displayed throughout the Facility. — 4					
	3. Documented policies and procedures for the service — 4					
	4. Policies and procedures are consistent with regulatory requirements and current standard practices. — 4					
	5. List of Policies and procedures that are relevant, updated, endorsed and dated. — 4					
	6. Evidence of periodic review — 4					
2.3.1.2 CORE	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.	4			4	
	EVIDENCE OF COMPLIANCE					
	1. Minutes of committee meetings on development and revision on policies and procedures. — 4					
	2. Minutes of meeting with evidence of cross reference with other departments. — 4					

	3.	Documented cross departmental policies	4					
2.3.1.3	Current policies and procedures are communicated to all staff.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	Training and briefing on the current policies and procedures/Minutes of meetings	4					
	2.	Circulation list and acknowledgement	4					
2.3.1.4 CORE	There is evidence of compliance with policies and procedures.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	Compliance with policies and procedures through:						
	a)	interview of staff on practices;	4					
	b)	verify with observation on practices;	4					
	c)	results of audit on practices;	4					
	d)	practices in line with established policies and procedures.	4					
2.3.1.5	Copies of relevant policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	Copies of relevant policies and procedures, protocols, guidelines, Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.	4					
	2.	Legal Register	4					
2.3.1.6	Current reference manuals, pamphlets, journals, and books as well as information and scientific data from manufacturers concerning their products used in the service (e.g. cleaning and antiseptic agents, etc) shall be readily available for reference and guidance.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	Hard/soft copies of relevant documents are accessible on-site and readily available for staff reference.	4					

TOPIC 2.4
FACILITIES AND EQUIPMENT

STANDARD 2.4.1
The Head of Environmental and Safety 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 Environmental and Safety Services.

CRITERION NO.	CRITERIA FOR COMPLIANCE			SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
2.4.1.1	There are adequate and appropriate facilities and equipment with proper utilisation of space to enable staff to carry out their professional and administrative functions.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	Adequate facilities and proper utilisation of space within the Facility for staff and outsourced service providers to carry out activities that affected by Environmental and Safety Services:						
	a)	adequate rooms/cabinets/work desks/ workshop areas;	4					
	b)	adequate storage space;	4					
	c)	no congestion is observed;	4					
	d)	Biannual Occupancy Evaluation Risk Assessment reports. The report shall include a), b) and c) above.	4					
2.4.1.2	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	Testing, commissioning and calibration records (certificates or stickers)	4					
	2.	Certificates of calibration, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc.	4					
	3.	Certification of equipment - Certificate of fitness (Department of Occupational Safety and Health certification, Fire Authority)	4					
2.4.1.3 CORE	Where specialised equipment (equipment that is high risk, require competency training and/or, complying to regulatory requirements) is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.			4			4	

	EVIDENCE OF COMPLIANCE						
	1.	List of personnel authorised by the Person In Charge (PIC) to operate specialised equipment.	4				
	2.	Training records	4				
	3.	Staff profile of authorised personnel	4				
	4.	Competency assessment records	4				
	5.	Certificate/registration of competent person as required or letter of authorisation.	4				
2.4.1.4	Provisions are made for the personal comfort of patients, visitors and staff. These include clean and hygienic facilities, appropriate room temperature and relative humidity and permissible noise levels.			4			4
	EVIDENCE OF COMPLIANCE						
	1.	Environmental audit reports	4				
	2.	Patient satisfaction survey reports	4				

TOPIC 2.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 2.5.1

The Head of Environmental and Safety Services shall ensure performance improvement with staff involvement in continuous safety and performance improvement activities of the Environmental and Safety Services. This can be achieved through monitoring and tracking of Hazard Identification, Risk Assessment and Risk Control (HIRARC) activities. The Head of Environmental and Safety 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
2.5.1.1 CORE	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Environmental and Safety 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.	4			4	
	EVIDENCE OF COMPLIANCE					
	1. Planned performance improvement activities include (a) to (f)	4				
	2. Records on performance improvement activities	4				
	3. Minutes of performance improvement meetings	4				
	4. Performance improvement studies	4				
	5. Records on innovation if available	4				
2.5.1.2	The Head of Environmental and Safety Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement activities to appropriate individual/personnel within the respective committees/activities.	4			4	
	EVIDENCE OF COMPLIANCE					
	1. Minutes of meetings	4				
	2. Letter of assignment of responsibilities	4				
	3. Terms of Reference/job description	4				

2.5.1.3 CORE	The Head of Environmental and Safety Services shall ensure that the staff are trained and complete incident reports involving patients, staff, visitors and outsourced service providers 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.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	System for incident reporting is in place, which include:						
	a)	Training of staff	4					
	b)	Procedure on incident/accident reporting	4					
	c)	Methodology of incident reporting	4					
	d)	Register/records of incidents	4					
	2.	Completed incident reports	4					
	3.	Root Cause Analysis	4					
	4.	Corrective and preventive action plans	4					
	5.	Remedial measure, Review of remedial measure for further improvement	4					
	6.	Reports to Relevant Authorities as required	4					
	7.	Minutes of meetings of ESH Committee	4					
	8.	Acknowledgment by Head of Service and PIC/Hospital Director	4					
	9.	Feedback given to staff regarding incident reporting.	4					
2.5.1.4 CORE	There is tracking and trending of specific performance indicators not limited to but at least two (2) of the following: a) percentage of issues identified during Environmental and Safety Audit areclosed or followed through. (Proposed Initial Target: 50%, 3 monthly report) b) percentage of internal and external planned drill are carried out and documented including recommendation and followed through. (Target: 100%) c) percentage of workplace hazards identified and risk managed (Target: 100%)			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	Specific performance indicators monitored.	4					
	2.	Records on tracking and trending analysis	4					
	3.	Records on workplace inspection and drills	4					

	4.	Records on analysis on Hazard Identification, Risk Assessment and Risk Control (HIRARC)	4				
	5.	Remedial measures taken where appropriate	4				
2.5.1.5	Feedback on results of safety and performance improvement activities are regularly communicated to the staff and relevant authority.			4			4	
	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 through continuing education activities/meetings.	4				
	3.	Minutes of committee meetings	4				
2.5.1.6	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				
2.5.1.7 CORE	There are safety and performance improvement activities that address patient/ staff / service user safety including the patient/ staff / service user of the outsourced service providers.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	Staff health screening	4				
	2.	Identification of health risk factors	4				
	3.	Infectious diseases prevention programme/activities	4				
	4.	Anti-smoking programme	4				
	5.	Healthy lifestyle 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.	Medical check-up record.	4					
	8.	Post exposure management	4					
	9.	Universal/standard precautions	4					
	10.	Protection against bullying and harassment	NA					
	11.	Effective management of under performance	NA					

TOPIC 2.6
SPECIAL REQUIREMENTS

STANDARD 2.6.1
ENVIRONMENT, SAFETY AND HEALTH PROGRAMMES
The Management of the Facility promotes Environment, Occupational Safety and Health programmes that ensure a safe and healthy environment for patients, staff, visitors and outsourced service providers.

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
2.6.1.1 CORE	There is a multidisciplinary Environmental Safety and Health (ESH) Committee for the purpose of planning, implementing and maintaining a comprehensive workplace safety programme including monitoring and reporting on incidents and accidents related to workplace safety and health of staff, in compliance with the Environmental Quality Act 1974 (Act 127) and Occupational Safety and Health Act (OSHA) 1994.	4			4	
	EVIDENCE OF COMPLIANCE					
	1. ESH Committee is established.	4				
	2. Organisation chart of ESH Committee	4				
	3. Terms of Reference of the ESH Committee	4				
	4. Schedule of meetings for the year	4				
	5. Minutes of meetings	4				
2.6.1.2	The Environmental Safety and Health (ESH) Committee shall be headed by top Management and supported by a Safety and Health Officer (SHO) registered with Department of Occupational Safety and Health (DOSH). The composition of the committee shall follow Occupational Safety and Health Act (OSHA) 1994 and Environmental Quality Act 1974 requirements. The letter of appointments shall clearly define the authority, responsibilities and accountabilities for the committee members.	4			4	
	EVIDENCE OF COMPLIANCE					
	1. Composition of the Committee is in accordance to the OSH Act 1994:					
	a) the Chairman of the committee shall be PIC/CEO	4				
	b) the secretary of the committee shall be the Safety and Health Officer;	4				

	c)	members are representatives of employees and employers from multidiscipline.	4				
	2.	Letter of appointment	4				
	3.	Job Scope as per Term of Reference	4				
2.6.1.3	There shall be Terms of Reference for the ESH Committee and clear committee organisational structure that shows coordinating functions between ESH Committee and specific subcommittees. EVIDENCE OF COMPLIANCE			4			4	
	1.	ESH Committee's organisation chart showing coordination with other specific committees.	4				
	2.	Committee's Terms of Reference	4				
2.6.1.4 CORE	There are planned activities that monitor and evaluate the performance of occupational safety and health programme. These activities include: a) conducting regular multidisciplinary environmental and safety inspections to ensure the workplace is safe, conducive, and comfortable to the staff, patients and visitors. The inspections shall be based on appropriate safety inspection checklists which shall include but not limited to: i) general safety on fire safety, facility, equipment and systems that pose risks; indoor air quality concerns; ii) security and comfort of occupants and; iii) hazardous materials management. b) the frequency of the environmental and safety inspections shall be in compliance with statutory regulations and professional best practices as determined by the ESH Committee; c) to promote healthy work culture programme and to conduct staff health surveillance especially to staff involved in high occupational hazards; d) conduct comprehensive risk assessment that includes identification of high risk areas, maintaining Risk Registers, carrying out Failure Mode and Effect Analysis (FMEA) and taking appropriate corrective actions to rectify the identified risks; e) investigation on reported incidents and accidents using Root Cause Analysis (RCA); f) To plan for recovery process if required to ensure business continuity g) follow-up action taken to evaluate the effectiveness of the corrective actions taken on identified high risks and on reported incidents and accidents to close the gap; h) reporting of OSH activities as required by law and regulations. i) Promote sustainability programmes that includes efficiency of use of energy, water, climate, and waste.			4			4	

	Note Risk register is taken to mean a register which records details of all the risks identified for an organisation, their grading in terms of likelihood of occurring and seriousness of impact on the organisation, initial plan for managing each high-level risk and subsequent results. **EVIDENCE OF COMPLIANCE** 1. Environment and Safety audit schedule and reports — 4 2. Risk Register and risk assessment report — 4 3. Health Promotion program: a) Stress management — NA b) Diet programme — NA 4. Staff health surveillance record and statistics — 4 5. Minutes of meetings, reports and records on environmental, occupational safety and health activities. — 4 6. Incident reports and RCAs — 4 7. Business Continuity Report on follow-up actions for further improvements — 4 8. Corrective and preventive measures — 4 9. Reports to relevant authorities, e.g., sharps injury to Ministry of Health, Lost Time Accident to Department of Occupational Safety and Health. — 4 10. Recovery plan for Business Continuity — 4 11. Sustainability Program — 4 12. Protection against bullying and harassment — NA 13. Effective management of under performance — NA					
2.6.1.5 CORE	There is a Safety and Health Officer whose authority, responsibilities and accountabilities for safety related activities are clearly defined and documented in a letter of appointment. **EVIDENCE OF COMPLIANCE** 1. Valid registration of Safety and Health Officer with Department of Occupational Safety and Health (DOSH). — 4	4			4	

	2.	Appointment of Safety and Health Officer	4				
	3.	Job description	4				
2.6.1.6	There is evidence that all staff are familiar with workplace environmental, safety and health programmes.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	Orientation checklist	4					
	2.	Attendance list	4					
	3.	Contents of orientation programme to include environmental, safety and health programme.	4					
	4.	Brochures, pamphlets and leaflets	4					
	5.	Staff knowledgeable on risks and hazards at their workplace.	4					
	6.	Staff comply with environmental, safety requirements	4					
2.6.1.7	There are written environmental and safety procedures specific to potentially hazardous areas and for hazardous substances (for example, central sterilising supply services, food services areas, laundries, laboratories, operating suites, radiation emission areas, special units, engineering rooms and workshops).			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	Departmental specific environmental and safety policies and procedures that include the following:						
	a)	Central Sterilising Supply Services (CSSS)	4					
	b)	Food Services	4					
	c)	Laundry	4					
	d)	Laboratory	4					
	e)	Operating suite	4					
	f)	Radiation Emission Areas	4					
	g)	Engineering rooms/workshop	4					
	h)	Laser safety program	4					
2.6.1.8	Special environmental and safety measures for facilities and equipment operation and maintenance are enforced for hazardous areas in accordance with applicable standards and the requirements of national and local statutory authorities. Written environmental and safety instructions and notes are readily available.			4			4	

	EVIDENCE OF COMPLIANCE						
	1.	Operation and maintenance of environmental and safety policies and procedures and work instructions e.g. Permit to Work/Construction Permit/Confine Space Entry Permit/LOTO	4				
	2.	Records on staff training	4				
	3.	Procedure checklist	4				
2.6.1.9	Personal protective clothing and equipment are provided where required, and their usage is monitored. Staff are provided with vaccination and/or medication as necessary to perform their work safely.			4			4	
	EVIDENCE OF COMPLIANCE						
	1.	Adequate supply of Personal Protective Equipment (PPE) and monitor stock balance.	4				
	2.	Staff wear proper PPE.	4				
	3.	Staff's vaccination record	4				
2.6.1.10	The following are standard environmental and safety practices that shall be complied with as follows: a) All portable gas cylinders are stored, restrained, and secured in accordance with applicable standards and the requirements of national and local statutory authorities. The requirements are: i) oxygen and flammable gases are stored separately from each other. ii) storage areas are ventilated, built of non-combustible material, and secured as appropriate. iii) all gas cylinders are restrained and stored in an upright position. iv) storage areas are appropriately labelled/sign posted including "No Smoking" sign in accordance with statutory requirements. b) There is provision of emergency suction apparatus and medical gas supplies in key areas such as operating suites, special care units, emergency services, etc. c) There has to be adequate lightings to service areas and there is provision of alternative light (emergency portable lightings) appropriate to the needs of the Facility in the event of a failure of the local supply.			4			4	
	EVIDENCE OF COMPLIANCE						
	1.	Compliance with items (a) to (c) by the Facility.	4				
2.6.1.11	The Facility shall ensure that noise, excessive smoke, foul odour or dust are minimised with evidence of surveillance report.			4			4	

	EVIDENCE OF COMPLIANCE						
	1.	Noise mapping	4				
	2.	Indoor air quality report	4				
	3.	Evidence of follow-up and follow through from recommendations made in the report	4				

STANDARD 2.6.2

FIRE SAFETY

All buildings within the Healthcare Facility shall be designed, constructed, equipped, operated and maintained in compliance with the relevant Acts, Statutory Regulations and Standards, ensuring safety to patients, visitors, staff and property from damages due to fire.

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
2.6.2.1 CORE	The building shall be equipped with active and passive protection system such as fire detection and suppression system, in compliance with statutory regulations, standards and professional best practices relating to fire safety. The fire detection systems shall be integrated and linked to the nearest fire station designated by the Fire Authority. Note: Refer to Fire Services Act 1988	4			4	
	EVIDENCE OF COMPLIANCE					
	1. Building drawing approved by Fire Authority — 4					
	2. Continuous Monitoring Information System (CMIS) is functional and linked to the fire station where applicable. — 4					
2.6.2.2 CORE	For all new buildings, renovation works and alterations to systems, there has to be documented evidence that the Fire Authority has approved the layout plan for fire safety. The drawings and design calculations shall be endorsed by Professional Engineer and/or Registered Architect.	4			4	
	EVIDENCE OF COMPLIANCE					
	1. Approved as built drawings by relevant professionals. — 4					
2.6.2.3 CORE	There is documented evidence that all buildings have been inspected by the Fire Authority annually and all risk issues identified during the inspections have been rectified to the satisfaction of the Fire Authority concerned. Note: Refer to Fire Service Act 1988	4			4	
	EVIDENCE OF COMPLIANCE					
	1. Annual fire inspection report by Fire Authority — 4					
	2. Current Fire Safety Certificate is available for buildings — 4					
	3. Facility's report on rectification of recommendations by Fire Authority where required. — 4					

2.6.2.4 CORE	Fire fighting equipment/system, such as fire extinguishers, hydrants, hose reels, fire blankets and fire suppression system are located at appropriate locations as per Fire Authority's requirements. The fire alarm systems are in proper functioning condition, and are being maintained and tested regularly, at least once every three (3) months or as required. EVIDENCE OF COMPLIANCE 1. Fire extinguishers have valid inspection certificates. 4 2. Testing of fire extinguishers 4 3. Maintenance records 4 4. Functional fire alarm system 4	4			4	
2.6.2.5	There are clear signages to indicate the location of fire fighting equipment and general instructions to use the equipment during emergency. EVIDENCE OF COMPLIANCE 1. Signages indicating fire fighting equipment are clearly visible. 4	4			4	
2.6.2.6	For passive fire protection, the buildings shall be compartmentalised appropriately to minimise the risk of the spread of fire and smoke. There are no open penetrations on walls, ceilings or walls to avoid smoke ingress. EVIDENCE OF COMPLIANCE 1. No penetrations at fire walls and zone compartments. 4	4			4	
2.6.2.7	All doors, corridors, ramps, and emergency stairways along the designated fire escape routes shall be kept free of obstruction at all times and are minimally 2.1 meters to allow for the evacuation of non-ambulatory patients, in compliance with relevant statutory regulations. EVIDENCE OF COMPLIANCE 1. Fire exit routes are unobstructed 4	4			4	
2.6.2.8	All fire doors shall be kept closed at all times (no door stopper allowed), except where permitted otherwise. In such cases, the fire doors may be held open by electrically operated door holder devices which can be set to release upon activation of the fire detection system. Fire doors shall not swing into the corridors. EVIDENCE OF COMPLIANCE	4			4	

	1.	Fire doors kept closed at all times.	4				
2.6.2.9	All fire escape routes and fire exit doors shall be identified with lighted "KELUAR" or "EXIT" sign as stipulated in the Fire Authority's regulations.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	Lighted KELUAR / EXIT signs are:						
	a)	clearly visible from any internal corridors	4					
	b)	functional;	4					
	c)	adequate.	4					
2.6.2.10 CORE	The evacuation route floor plans shall be displayed at the entrances of every department. The assembly areas have to be a secured open space at a safe distance away from the building. There is signage to direct evacuees to the assembly area in case the assembly areas could not be seen when evacuees exiting the building.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	Current evacuation plans are available.	4					
	2.	Clear signage to assembly areas	4					
2.6.2.11	There are adequate "No Smoking" signs posted at all entrances to the Facility.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	No Smoking" signs are:						
	a)	visible;	4					
	b)	adequate;	4					
	c)	placed at all entrances to the Facility.	4					
2.6.2.12 CORE	There is at least one designated Fire Safety Officer assigned by the Person In Charge for every shift. The Fire Safety Officer(s) shall have the relevant training to ensure that they can be responsible for fire safety at the Facility all times.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	Assignment letter	4					
	2.	Fire Response Training records	4					
	3.	Minutes of fire safety meetings	4					

2.6.2.13 CORE	The Emergency Response Team (ERT) and key Incident Management Team (IMT) shall be adequately equipped to respond during emergency. EVIDENCE OF COMPLIANCE 1. ERT and IMT are established. 4 2. Emergency procedures and disaster control room facilities are available. 4 3. Training records 4 4. Minutes of fire safety meetings 4		4			4	
2.6.2.14 CORE	The fire evacuation plans and procedures shall include: a) the assignment of personnel to specific tasks and responsibilities, e.g. IMT,ERT, floor wardens, etc; b) instructions for the use of alarm systems and signals; c) information concerning methods of fire containment and suppressions; d) information concerning the location of fire fighting equipment; e) systems for notification of appropriate persons; f) evacuation process, maps on evacuation routes, assembly points; g) head count process; h) activation of the fire emergency plans (Code Red) or other emergency plans where warranted; i) ensure smooth recovery back to normal operation j) if major fire incident, business recovery plan should be activated k) other provisions as the local situation dictates. EVIDENCE OF COMPLIANCE 1. Approved fire evacuation and recovery plan and procedures that include items (a) to (k). 4 2. Staff awareness on fire evacuation plan and procedures 4 3. Staff assignment and response card 4 4. Training records for all staff including on-site outsourced staff including 4		4			4	
2.6.2.15 CORE	There is documented evidence that fire drills had been planned and executed every year (minimum once a year) involving different Units/Sections/Departments and conducted under varied conditions. Major evacuation has to be done with the assistance of the local Fire Authority (BOMBA). There are written reports and evaluations on all drills, and documentation of staff attendances.		4			4	

	EVIDENCE OF COMPLIANCE						
	1.	Records and reports on annual fire drills	4				
	2.	Staff attendance list	4				
2.6.2.16	The general contingency plan for fire and evacuation shall be understood by all staff and on-site outsourced staff and tenants. Key assigned personnel shall be trained in more advanced aspects of fire safety, including fire notification procedures, fire alarm, use of fire fighting equipment, fire evacuation procedures and evacuation of non-ambulant patients.			4			4	
	EVIDENCE OF COMPLIANCE						
	1.	Staff awareness on fire and evacuation plan	4				
	2.	Records on training of key assigned personnel and staff on specific aspects of fire safety	4				

STANDARD 2.6.3

DISASTER MANAGEMENT

The Facility has written plans to deal with internal and external disasters. Plans are coordinated with statutory and civil authorities as appropriate. The Person In Charge (PIC) of the Healthcare Facility shall ensure there are documented contingency plans to deal with identified disasters, in compliance with the relevant statutory regulations, and as follows:
a) External Disaster Plan (also classified as Community Affected – Healthcare Facility Unaffected): during such scenarios, the Healthcare Facility plays a vital role in the disaster response being undertaken. For the Healthcare Facility, such scenarios would imply a sudden increase in demand for patient care services because of the surge in the number of patients seeking medical attention. There is a possibility of the Healthcare Facility getting overwhelmed if adequate preparedness and response mechanisms are not swung into action as soon as the disaster is reported.
b) Internal Disaster Plans (also classified as Community Unaffected – Healthcare Facility Affected): Such scenarios arise from the internal disasters within the Healthcare Facility. As such, partial or complete evacuation and transfer of critical patients to networking facilities is the key to successful response. Such scenarios also demand a high degree of preparedness on the side of the Facility administration and staff, as well as a speedy response from the surrounding community and Healthcare Facilities.
c) Business Recovery Plan – For both internal and external disasters, business recovery plan shall be available for the facility to normalcy after the event. It should be noted that the Healthcare Facility may experience sudden loss of essential services, such as water supply, electricity, medical gases, telephone services, etc. Hence, the Healthcare Facility should have appropriate contingency plans for such interruptions, ensuring that the workplace safety is not compromised.

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
2.6.3.1	EXTERNAL DISASTER PLANS The Facility has an appropriate external disaster plan, based on its capabilities and as follows: a) the external disaster plan is developed in consultation with relevant statutory and civil authorities, relevant Non-Governmental Organisations and other service agencies supporting the locality. The plan is to establish an effective chain of command, clarify matters of jurisdiction, and coordinate the Facility's activities with the activities of these agencies. Where deemed necessary, a standing External Disaster Committee shall be established, with the Chairperson being appointed in writing by the Person In Charge (PIC); b) the scope of the Facility's roles and resources shall be made known to the local police, Fire Authority, the state emergency services, associated supporting ambulance teams, other healthcare facilities and the community; c) the disaster plan provides for: i) consideration of the type of disasters likely to occur; ii) limits of casualties when the disaster plan should be activated; \ iii) defined authority and control; iv) assignment of staff to specific tasks and responsibilities; v) identification for staff involved in the plan (e.g. special vest, etc); vi) an efficient system of notifying staff (response card); vii) effective communication systems within and outside the Facility; viii) availability of adequate basic utilities and supplies including gas, water, electricity, food, and essential medical and support materials; ix) conversion of all appropriate spaces into clearly defined areas for efficient triage, patient observation and immediate care;	4			4	

	x) transportation arrangements when necessary for prompt transfer of casualties to the Facility most appropriate for administering definitive care, after preliminary emergency medical or surgical services have been rendered; xi) making available a list of casualties and appropriately designed tags to accompany each casualty; xii) arrangements for the prompt discharge or transfer of current inpatients who can be moved without harm; xiii) maintaining security in order to keep unauthorised persons away from the triage area; xiv) the establishment of a public information centre and assignment of public relations duties to a suitable person; a media communication plan will help to provide organised dissemination of information; xv) debriefing and disaster plan review procedures. d) the external disaster plan involving the medical practitioners, other relevant staff and external agencies such as the police, Fire Authority, etc and shall be tested for its capability at least once a year in order to: i) ensure that all responsible staff are provided with training to enable performance of assigned tasks; ii) evaluate the effectiveness of the plan; iii) evaluate and document the exercise; iv) review and revise the plan as necessary. EVIDENCE OF COMPLIANCE 1. External Disaster Plan that addresses items (a) to (c). 4 2. List of relevant agencies and their contact numbers 4 3. Adequate resources as per disaster plan 4 4. Records on relevant staff training on the disaster plan 4 5. Staff response card 4 6. Drills and training records 4 7. Reports on the Disaster Drill and actual disaster (if applicable) 4 8. Evaluation on Disaster Drill and actual disaster (if applicable) 4 9. Revision of External Disaster Plan as necessary 4					
2.6.3.2 CORE	INTERNAL DISASTER PLANS The Facility shall have documented internal disaster plans for all anticipated occurrence of incidences that would have adverse effect on patients, visitors and staff as follows: a) Fire/Explosion b) Bomb threat c) Evacuation	4			4	

	d) Physical Assault/Security Threat e) Baby abduction f) Facilities system failure including IT Systems g) Major chemical spillage/radiation leaks h) Medical Emergencies i) Emergencies in Delivery Suite and Operating Rooms j) Biological threats including infectious disease A code system normally using colour as identifier is used to identify the emergency status to avoid unnecessary panic if the code is announced via public address system.					
	EVIDENCE OF COMPLIANCE					
	1.	Internal Disaster Plan that include potential internal disasters (a) to (i).	4			
	2.	Internal Disaster Plan with specified colour codes	4			
	3.	List of relevant agencies and their contact numbers	4			
	4.	Adequate resources as per disaster plan	4			
	5.	Records on relevant staff training on the Internal Disaster Plan	4			
	6.	Staff response card	4			
	7.	Reports on the Disaster Drill and actual disaster (if applicable)	4			
	8.	Revision of Internal Disaster Plan as necessary	4			
2.6.3.3 CORE	(a) The Internal Disaster Plan shall include but not limited to: i) establishment of disaster management team with clear reporting line; ii) activation of the plans and disaster command centre; iii) assignment of personnel to specific tasks and responsibilities; iv) instructions for the use of alarm systems and signals; v) information concerning methods of hazards management and area isolation, e.g. fire containment; vi) information concerning the location of emergency equipment, e.g. fire fighting equipment, fire protected lobby, etc; vii) systems for notification of appropriate persons/authority and/or announcement to public or groups; viii) maps on evacuation routes and directional signage for assembly areas; ix) requirements for medical support for mass casualties, e.g. medical based for resuscitation area or handling trauma; x) post event management, e.g. investigation, insurance, relevant authorities, relatives, etc; b) The internal disaster plans are tested for its capability at least once a year in order to:		4			4	

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i) ensure that all staff are provided with training to enable performance of assigned tasks;
ii) evaluate the effectiveness of the plan;
iii) evaluate and document the exercise;
iv) review and revise the plan as necessary.
c) The Internal Disaster Plan shall be readily available for staff reference. d) Staff are familiar with the internal disaster plans and shows understanding of the plans that are displayed throughout the Facility.
<table>
<tr><th colspan="3">EVIDENCE OF COMPLIANCE</th></tr>
<tr><td>1.</td><td>Appropriate Internal Disaster Plan that addresses items (a)(i) to (a)(x).</td><td>4</td></tr>
<tr><td>2.</td><td>Designated Command Centre</td><td>4</td></tr>
<tr><td>3.</td><td>Drills and training records</td><td>4</td></tr>
<tr><td>4.</td><td>Reports on the Disaster Drill and actual disaster (if applicable)</td><td>4</td></tr>
<tr><td>5.</td><td>Evaluation on Disaster Drill and actual disaster (if applicable)</td><td>4</td></tr>
<tr><td>6.</td><td>Revision of Internal Disaster Plan as necessary</td><td>4</td></tr>
<tr><td>7.</td><td>Control copy of Internal Disaster Plan is easily accessible to staff.</td><td>4</td></tr>
<tr><td>8.</td><td>Staff awareness on Internal Disaster Plan</td><td>4</td></tr>
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<td>2.6.3.4</td>
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Disaster Recovery Plan shall be formulated for all major disasters that affected normal hospital service operation including the following:
a. Effort to restore operation to normalcy and repair damages to its original condition
b. To ensure that aspects of physical and mental health of patients, family members and staff been taken care of.
c. To conduct post mortem to identify better precautionary steps and improving the disaster management process
d. Continuously improve the preventive and mitigation measures in recovery plan for the future
<table>
<tr><th colspan="3">EVIDENCE OF COMPLIANCE</th></tr>
<tr><td>1.</td><td>Appropriate Business Recovery Plan that addresses item 1 to 5</td><td>4</td></tr>
<tr><td>2.</td><td>Reports of business recovery after disaster</td><td>4</td></tr>
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STANDARD 2.6.4

HAZARDOUS MATERIAL MANAGEMENT

Hazardous materials include chemicals, radioactive materials and scheduled waste. Handling of chemicals including the collection, storage, transportation and disposal of all healthcare wastes shall be properly managed in compliance with relevant statutory regulations (such as the Environmental Quality Act 1974 (Act 127) and subsequent amendments and the subsidiary legislation referring to scheduled waste, prescribed premises, prescribed activities, Prevention and Control of Infectious Diseases Act 1988, Atomic Energy Licensing Act 1984, etc) and professional best practices as agreed by the Environmental and Safety Committee.

CRITERION NO.	CRITERIA FOR COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
2.6.4.1 CORE	All chemicals and types of healthcare wastes (clinical, cytotoxic, radioactive, spent reused oil etc.) shall be defined, identified and labelled appropriately as required.		4			4	
	EVIDENCE OF COMPLIANCE						
	1.	Valid report on Chemical Health Risk Assessment by competent person.	4				
2.6.4.2 CORE	Staff that handle chemicals and healthcare facility wastes need to be trained on proper handling and disposal of such wastes.		4			4	
	EVIDENCE OF COMPLIANCE						
	1.	Records on staff training	4				
2.6.4.3	Staff shall wear appropriate personal protective equipment when handling hazardous materials.		4			4	
	EVIDENCE OF COMPLIANCE						
	1.	Staff and contractors wear appropriate personal protective equipment.	4				
2.6.4.4	Staff shall be trained to handle spillage and appropriate spill kits are located appropriately.		4			4	
	EVIDENCE OF COMPLIANCE						
	1.	Policy and procedures on handling spillage	4				
	2.	Staff able to demonstrate the procedures on handling spillage	4				
	3.	Adequate spillage kits are available.	4				
2.6.4.5 CORE	Wastes requiring special processing (such as radioactive, cytotoxic and sharps) shall be segregated at the point of origin, appropriately labelled during collection in		4			4	

	compliance with the relevant regulations and guidelines, collected in approved colour-coded bags and sharps containers by appropriately trained staff, stored in designated storage facility with proper temperature controls, and with hand washing facility and wastewater drainage. **EVIDENCE OF COMPLIANCE** 1. Chemical and scheduled wastes are properly labelled and not mixed with other wastes. 4 2. Appropriate storage facilities for: a) clinical waste; 4 b) chemical and chemical waste; 4 c) electronic waste; 4 d) radioactive waste. 4 3. Eyewash and shower for chemical handling 4 4. Handwashing facilities 4					
2.6.4.6	Chemicals and healthcare wastes shall be appropriately stored as follows: a) inflammable, acid/base chemicals shall be kept separately in metal cabinets; b) the chemical and scheduled waste store shall be well ventilated andequipped with spillage containment; c) the clinical waste store shall be refrigerated if the wastes are stored for more than 24 hours. **EVIDENCE OF COMPLIANCE** 1. Proper storage including containment of chemicals in appropriate and right size cabinets and/or rooms. 4 2. Clinical waste store is refrigerated at temperature 4°C - 6°C if the wastes are stored for more than 24 hours. 4	4			4	
2.6.4.7	There has to be a dedicated route for waste transportation. No mixing between clean and dirty waste materials. **EVIDENCE OF COMPLIANCE** 1. Policy and procedures address the route/timing of waste transportation. 4 2. Dedicated route for transportation of waste. 4	4			4	

2.6.4.8 CORE	All scheduled wastes shall be transported to the final disposal site in dedicated vehicles licensed by the Department of Environment.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	Approval letter from Department of Environment for transporting scheduled waste outside the premises.	4					
	2.	Consignment note available.	4					

STANDARD 2.6.5

DOMESTIC AND RECYCLED WASTE

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

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
2.6.5.1	Domestic, recycled and food wastes shall be removed daily and the main storage area shall be kept clean. EVIDENCE OF COMPLIANCE 1. Domestic, recycled and food wastes areas are kept clean. (4) 2. Schedule on collection of domestic, recycled and food wastes from local authority/local contractors. (4)	4			4	
2.6.5.2	Recycle waste shall be separated at source using the designated containers. No waste segregation is allowed at the central waste storage. EVIDENCE OF COMPLIANCE 1. Policy and procedures for recycling waste (4) 2. Compliance with policy and procedures (4)	4			4	

STANDARD 2.6.6

SECURITY SERVICES

Security measures are taken to ensure the protection of patients and staff from assault and loss of property; and the Facility from damage and loss.

CRITERION NO.	CRITERIA FOR COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
2.6.6.1 CORE	Regular security risk assessment shall be carried out by a Committee appointed by the Person In Charge so as to identify potential security risks in the Facility.		4			4	
	EVIDENCE OF COMPLIANCE						
	1.	Valid Security Risk Assessment Report	4				
2.6.6.2 CORE	Appropriate security measures shall be taken to ensure the protection of patients, staff and visitors. These may include staff, visitors and contractors access control, closedcircuit television (CCTV) monitoring, key control, duress alarm systems, adequate lighting, and security protection for personal belongings, payroll, drugs, and other assets of the Facility.		4			4	
	EVIDENCE OF COMPLIANCE						
	1.	Functional security system is available, e.g. card access, CCTV, locks, barrier, lighting, duress alarm, etc.	4				
	2.	Recommend CCTV to have minimum 14 days of storage capacity	4				
	3.	Procedure and practice of control access after visiting hours	4				
	4.	Reports on performance of the security system	4				
	5.	Security incident reports	4				
2.6.6.3	There are adequate and well trained security personnel for the Facility such that the presence of security is felt to deter potential criminal activities.		4			4	
	EVIDENCE OF COMPLIANCE						
	1.	Security personnel is present at important areas at all times.	4				
	2.	Records on clearance from Ministry of Internal Affairs for all security personnel	4				
	3.	Training records on security personnel	4				

STANDARD 2.6.7

VECTOR AND PEST CONTROL SERVICES

Healthcare buildings are ideal places for the breeding of various categories of vectors and pests such as insects (ants, termites, cockroaches, flies, etc.), rodents (rats, mice, etc.) and stray animals (dogs, cats, snakes, etc). Healthcare Facilities infested by vectors and pests can be high risks for transmitting of infections and diseases.

CRITERION NO.	CRITERIA FOR COMPLIANCE			SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
2.6.7.1 CORE	There is documented evidence that a comprehensive vector and pest control programme throughout the hospital including tenanted areas is being implemented in a scheduled manner and monitored regularly.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	Vector and pest control schedule as per agreement and records on activities.	4					
2.6.7.2	Vector and pest control includes the extermination and control of unwanted insects (ants, termites, cockroaches, mosquitoes, etc.) and rodents (rats, etc.), as well as removal of stray animals (cats, dogs, birds, etc.). Some of the vector and pest control activities have to be scheduled as per agreement and approval of the Healthcare Facility Management. Vectors and pests shall not be seen in the facility buildings and grounds.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	No vectors and pests seen in the facility buildings and grounds.	4					
2.6.7.3	There is planned regular vector control programme.			4			4	
	EVIDENCE OF COMPLIANCE							
	1.	Dengue control activities	4					
	2.	Records on inspection of mosquito breeding areas	4					

SERVICE SUMMARY	
-	
OVERALL RATING :	NA
OVERALL RISK :	-