SERVICE STANDARD 24: STANDARDS FOR GENERAL APPLICATION – QUALITY UNIT

PREAMBLE

This chapter contains general criteria for the assessment or review of specific functions or services which are an integral part of the organisational structure of the Facility and for which a specific set of standards are not yet developed. Some of these services or units may need to have additional criteria developed which are particular to them and applied within reason depending on range and scope of services provided.

TOPIC TOPIC 24.1
ORGANISATION AND MANAGEMENT

STANDARD STANDARD 24.1.1

The Service is organised and administered to provide optimum care for patients according to the goals and objectives of the Facility and to meet the needs of the patient population being served.

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
24.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Service are clearly documented and measurable. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff EVIDENCE OF COMPLIANCE 1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body. — NA 2. Goals and objectives of the Service in line with the Facility statements are available, endorsed and dated. — NA 3. Evidence of planned reviews of the above statements — NA 4. These statements are communicated to all staff (orientation programme, minutes of meeting, etc) — NA 5. Achievement of goals and objectives are monitored, reviewed and revised accordingly. — NA	NA			NA	
24.1.1.2 CORE	There is an organisation chart which: a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head and staff of the Service; b) is accessible to all staff and clients;	NA			NA	

	c) includes off-site services if applicable; d) is revised when there is a major change in any of the following: • i) organisation; • ii) functions; • iii) reporting relationships; • iv) staffing patterns. **EVIDENCE OF COMPLIANCE** 1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head and staff of the Service. — NA 2. Organisation chart of the service is endorsed, dated and accessible. — NA 3. The organisation chart is revised when there is a major change in any of the items (d)(i) to (iv). — NA					
24.1.1.3	Regular staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Service. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented. **EVIDENCE OF COMPLIANCE** 1. Minutes are accessible, disseminated and acknowledged by the staff. — NA 2. Attendance list of members with adequate representatives of the service. — NA 3. Frequency of meetings as scheduled. — NA 4. Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved) — NA	NA			NA	
24.1.1.4	The Head of Service is involved in the planning, justification and management of the budget and resource utilisation of the services. **EVIDENCE OF COMPLIANCE** 1. Minutes of Facility-wide management meeting — NA	NA			NA	

	2.	Documented evidence on request for allocation of budget and resources (staffing, equipment, etc) for the service.	NA				
	3.	Approved budget and resources.	NA				
24.1.1.5	The Head of Service is involved in the appointment and/OR assignment of staff.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Records on staff interview	NA					
	2.	Appointment/assignment letter of Head of Service	NA					
	3.	Job description of Head of Service	NA					
	4.	Records on staff deployment	NA					
	5.	Duty roster	NA					
24.1.1.6	Appropriate statistics and records shall be maintained in relation to the provision of Service and used for managing the services and patient care purposes.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Records are available but not limited to the following:						
	a)	workload/census;	NA					
	b)	annual report;	NA					
	c)	accident/incident reports;	NA					
	d)	staffing number and staff profile;	NA					
	e)	staff training records;	NA					
	f)	data on performance improvement activities, including performance indicators	NA					
24.1.1.7	Where staff provide direct care to patients, a notation is made in the patient's medical record that care has been given. Where appropriate, response to care is also recorded. Such records are signed, dated, and designation stated.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Notation in the patient’s medical record that cares has been given.	NA					
	2.	Response to care is recorded.	NA					
	3.	Records are signed, dated, and designation stated.	NA					

24.1.1.8	Where services are provided from an external source there is a written agreement between the external service provider and the Facility stating the requirements for service delivery, including the following: 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 committees of the Facility; d) arrangement for adequate pickup and delivery; e) arrangements for after-hours and emergency services; f) mechanisms for dealing with problems in service delivery; g) adequate facilities and equipment for providing the services at the Facility, and at the site of the external service; 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 that part of the service which functions within the Facility EVIDENCE OF COMPLIANCE 1. Written agreement which include (a) to (i) between the external service provider and the Facility is endorsed, signed and dated. — NA	NA			NA	

TOPIC TOPIC 24.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD STANDARD 24.2.1
The Service shall be directed by a person qualified in the specific services and assisted by sufficient qualified support staff to enable fulfilment of the services' aims and objectives and ensure continuing education and development.

CRITERION NO.	CRITERIA FOR COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
24.2.1.1	The Head and staff of the Service shall be individuals qualified by education, training, experience and certification to commensurate with the requirements of the various positions.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Records on credentials of Head of Service and staff required to fill up the posts within the service (to match the complexity of the Facility and services) and certification/registration.	NA				
	2.	Appointment/assignment letters	NA				
	3.	Certification	NA				
	4.	Training and competency records	NA				
24.2.1.2	The authority, responsibilities and accountabilities of the Head of Services are clearly delineated and documented.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Appointment/assignment letter for Head of Service.	NA				
	2.	Description of duties and responsibilities.	NA				
24.2.1.3	Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the need of the services.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Number of staff and qualification should commensurate with workload.	NA				
	2.	Staffing pattern	NA				
	3.	Duty roster	NA				

	4.	Census and statistics	NA				
24.2.1.4	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 any of the following: • i) nature and scope of work; • ii) duties and responsibilities; • iii) general and specific accountabilities; • iv) qualifications required and privileges granted; • v) staffing patterns; • vi) Statutory Regulations. e) administrative and clinical functions.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e).	NA				
	2.	Job description includes specialisation skills	NA				
	3.	Relevant privileges granted where applicable	NA				
	4.	The job description is acknowledged by the staff and signed by the Head of Service and dated.	NA				
24.2.1.5	Personnel records on training, staff development, leave and others are maintained for every staff. Note: Staff personal record may be kept in Human Resource Department as per Facility policy.		NA			NA	

	EVIDENCE OF COMPLIANCE						
	1.	Staff personal records include:					
	a)	staff biodata;	NA				
	b)	qualification and experience;	NA				
	c)	training record;	NA				
	d)	competency record and privileging;	NA				
	e)	eave record;	NA				
	f)	confidentiality agreement.	NA				
24.2.1.6	There is a structured orientation programme where new staff are briefed on their services, operational policies and relevant aspects of the Facility to prepare them for their roles and responsibilities.			NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Policy requiring all new staff to attend a structured orientation programme.	NA				
	2.	Records on structured orientation programme	NA				
	3.	Orientation Brief	NA				
	4.	List of attendance	NA				
24.2.1.7	There is evidence of training needs assessment and staff development plan which provides the knowledge and skills required for staff to maintain competency in their current positions and future advancement.			NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Training needs assessment is carried out and gaps identified.	NA				
	2.	A staff development plan based on training needs assessment is available.	NA				
	3.	Training schedule/calendar is in place.	NA				
	4.	Training module	NA				
24.2.1.8	There are continuing education activities for staff including medical practitioner to pursue professional interests and to prepare for current and future changes in practice.			NA			NA	
	EVIDENCE OF COMPLIANCE						

	1.	Training calendar includes in-house/external courses/workshop/conferences	NA				
	2.	Contents of training programme	NA				
	3.	Training records on continuing education activities are kept and maintained for each staff including training in life support.	NA				
	4.	Certificate of attendance/degree/post basic training.	NA				
24.2.1.9	Staff receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Performance appraisal for staff is completed upon probationary period and as an annual exercise.	NA				
24.2.1.10	In a teaching hospital, the Service shall provide educational needs and teaching for undergraduates and postgraduates without compromising patient safety and comfort.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Sufficient skilled and trained staff to provide clinical supervision	NA				
	2.	Memorandum of Understanding.	NA				
24.2.1.11	In Facilities which have teaching and research responsibilities, the staff of the Service give their cooperation or participate in the teaching and research programmes.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Letter of appointment – Local Preceptor/ Clinical Instructor	NA				
	2.	Qualification and training records of local preceptor.	NA				

TOPIC TOPIC 24.3
POLICIES AND PROCEDURES

STANDARD STANDARD 24.3.1
There are documented policies and procedures that reflect current knowledge and practice for the services and are consistent with goals and objectives of the services and relevant regulations and statutory requirements.

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
24.3.1.1 CORE	There are written policies and procedures for the Service which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated. There is a mechanism for and evidence of a periodic review at least once in every three years. **EVIDENCE OF COMPLIANCE** 1. Documented policies and procedures for the service — NA 2. Policies and procedures are consistent with regulatory requirements and current standard practices. — NA 3. Evidence of periodic review of policies and procedures. — NA 4. The policies and procedures are endorsed and dated. — NA	NA			NA	
24.3.1.2	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved. Cross departmental collaboration is practised in developing relevant policies and procedures where applicable **EVIDENCE OF COMPLIANCE** 1. Minutes of committee meetings on development and revision on policies and procedures. — NA 2. Minutes of meeting with evidence of cross reference with other departments — NA 3. Documented cross departmental policies — NA	NA			NA	
24.3.1.3	Current policies and procedures are communicated to all staff.	NA			NA	

	EVIDENCE OF COMPLIANCE						
	1.	Training and briefing on the current policies and procedures/Minutes of meetings	NA				
	2.	Circulation list and acknowledgement	NA				
24.3.1.4 CORE	There is evidence of compliance with policies and procedures.			NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Compliance with policies and procedures through:					
	a)	interview of staff on practices;	NA				
	b)	verify with observation on practices;	NA				
	c)	results of audit on practices;	NA				
	d)	practices in line with established policies and procedures.	NA				
24.3.1.5	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, ByLaws and statutory requirements are accessible to staff.			NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.	NA				

TOPIC TOPIC 24.4
FACILITIES AND EQUIPMENT

STANDARD STANDARD 24.4.1
Adequate facilities and equipment are available to enable the services to meet their purposes.

CRITERION NO.	CRITERIA FOR COMPLIANCE			SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
24.4.1.1	There are adequate and appropriate facilities and equipment with proper utilisation of space to enable staff to carry out their professional and administrative functions.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Adequate and proper utilisation of space.	NA					
	2.	Appropriate type of equipment to match the complexity of services.	NA					
	3.	Easy access and clear exit routes	NA					
	4.	Absence of overcrowding	NA					
24.4.1.2	There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Testing, commissioning and calibration records (certificates or stickers)	NA					
	2.	Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), etc as evidence of compliance to the relevant standards and Acts.	NA					
24.4.1.3 CORE	There is evidence that the Facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Planned Preventive Maintenance records such as schedule, stickers, etc.	NA					
	2.	Planned Replacement Programme where applicable	NA					
	3.	Complaint records	NA					

	4.	Asset inventory	NA				
24.4.1.4	Where specialised equipment is used, there is evidence that only staff who are trained and authorised by the Facility operate such equipment.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	User training records	NA				
	2.	Competency assessment record	NA				
	3.	Letter of authorisation	NA				
	4.	List of staff trained and authorised to operate specialised equipment	NA				

TOPIC TOPIC 24.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD STANDARD 24.5.1
The Head of Service shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Service.

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
24.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the Service. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated. EVIDENCE OF COMPLIANCE 1. Planned performance improvement activities include (a) to (f — NA 2. Records on performance improvement activities. — NA 3. Minutes of performance improvement meetings — NA 4. Performance improvement studies — NA 5. Records on innovation if available — NA	NA			NA	
24.5.1.2	The Head of Service has assigned the responsibilities for planning, monitoring and managing safety and performance improvement to appropriate individual / personnel within the respective services. EVIDENCE OF COMPLIANCE	NA			NA	

	1.	Minutes of meetings	NA				
	2.	Letter of assignment of responsibilities	NA				
	3.	Terms of Reference/Job description	NA				
24.5.1.3	The Head of the Service shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility. Incidents reported have had Root Cause Analysis done and action taken within the agreed timeframe to prevent recurrence.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	System for incident reporting is in place, which include:						
	a)	Training of staff	NA					
	b)	Policy on incident reporting	NA					
	c)	Methodology of incident reporting	NA					
	d)	register/records of incidents	NA					
	2.	Completed incident reports	NA					
	3.	Root Cause Analysis	NA					
	4.	Corrective and preventive action plans	NA					
	5.	Remedial measure	NA					
	6.	Minutes of meetings	NA					
	7.	Acknowledgment by Head of Service and PIC/Hospital Director	NA					
	8.	Feedback given to staff regarding incident reporting.	NA					
24.5.1.4 CORE	There is tracking and trending of at least two (2) specific performance indicators relevant to the service.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Specific performance indicators monitored.	NA					
	2.	Records on tracking and trending analysis.	NA					
	3.	Remedial measures taken where appropriate.	NA					
24.5.1.5	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.			NA			NA	

	EVIDENCE OF COMPLIANCE						
	1.	Results on safety and performance improvement activities are accessible to staff.	NA				
	2.	Evidence of feedback via communication on results of performance improvement activities through continuing education activities/meetings.	NA				
	3.	Minutes of service meetings	NA				
24.5.1.6	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Documentation on performance improvement activities and performance indicators.	NA				
	2.	Policy statement on anonymity on patients and providers involved in performance improvement activities.	NA				

SERVICE SUMMARY	
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OVERALL RATING :	NA
OVERALL RISK :	-