SERVICE STANDARD 06: PATIENT AND FAMILY RIGHTS

PREAMBLE

Every patient is unique; with his/her own needs, values and beliefs and religion. Healthcare facilities and services providers need to establish confidence, trust and clear communication with patients and family. Healthcare providers need to understand and protect each patient's and family's cultural and psychosocial beliefs and religion.

Outcomes of patient care are safer and much improved when patients and their families or others who make decisions, participate in care decisions and process in a way that meets their expectations.

The standards focus on how Patient and Family Rights processes are carried out in the Facility to provide healthcare in an equitable manner considering the delivery system and cost of treatment.

The standards also address the rights of patients and families related to research and to the donation and transplantation of organs and tissues.

TOPIC 6.1:
PATIENT AND FAMILY RIGHTS

STANDARD 6.1.1

The Facility is responsible for providing processes that support patient and family rights from the point of accessing care.

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

	h) appropriate counseling prior to being granted discharge from the hospital against medical advice; i) information of applicable and relevant Facility rules and policies; j) administration of pain management where appropriate; k) advice on the approximate cost of treatment prior to the provision of care; l) information regarding financial and other assistance that may be available; m) receipt and examination of an itemised statement of all charges; n) information of the responsibilities of patients and families; o) access to health promotion information to facilitate their treatment in the Facility; p) access to information on quality and performance improvement in the Facility; q) provision of relevant information on the procurement, donation process and transplantation process where necessary. EVIDENCE OF COMPLIANCE 1. There is documented Patient and Family Rights Policy as identified in relevant laws and regulations that address items (a) to (q). NA 2. Information on patient admission or entry process is is provided to the patient. e.g hospital website, information counter,help desk, admission counter,etc NA					
6.1.1.2	The Person In Charge (PIC) ensures implementation of Patient and Family Rights in the Facility. EVIDENCE OF COMPLIANCE 1. Job description of PIC related patient's grievance NA 2. Minutes of meetings NA	NA			NA	
6.1.1.3 CORE	Policies and procedures guide the implementation of Patient and Family Rights in the Facility. EVIDENCE OF COMPLIANCE 1. On-site observation on compliance with policies and procedures. NA	NA			NA	
6.1.1.4	Staff are educated/trained and knowledgeable about the policies and procedures related to Patient and Family Rights and can explain their responsibilities in protecting patient's rights. EVIDENCE OF COMPLIANCE 1. Records on training programme on Patient and Family Rights NA	NA			NA	

STANDARD 6.1.2

Care provided is considerate and respectful of the patient's personal values, beliefs and religion. The Facility has a process to respond to patient and family's request for services related to patient's personal values and spiritual beliefs and religion.

CRITERION NO.	CRITERIA FOR COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
6.1.2.1 CORE	There is a process designed to identify and respect patient's personal values, beliefs and religion and where applicable those of the patient's family.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Patient's religion and beliefs are identified	NA				
	2.	Orientation checklist addresses the needs of patient.	NA				
6.1.2.2	Staff use the process and provide care that is respectful of the patient's personal values, beliefs and religion.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Provision of choice of menu	NA				
	2.	Information on religious activities, where appropriate.	NA				
	3.	Evidence of acknowledgement of patient's special request.	NA				
6.1.2.3	The Facility responds to routine as well as complex requests related to religious beliefs/support centres.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Availability of contact number/person of respective religious beliefs/support centres.	NA				

STANDARD 6.1.3

Care is respectful of the patient's need for privacy especially during clinical interviews, examinations, procedures and treatments. Patient may desire privacy from other staff, other patients or even from family members.

CRITERION NO.	CRITERIA FOR COMPLIANCE			SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
6.1.3.1	There is a process designed for staff to ensure patient's needs for privacy during care and treatment.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Policy on patient privacy during care and treatment	NA					
	2.	On-site observation on compliance with above policy.	NA					
6.1.3.2	A patient's expressed need for privacy is respected. There is no sharing of rooms during clinical interviews, examinations, procedures and treatments.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	On-site observation on compliance to ensuring patient privacy.	NA					
6.1.3.3	There is a policy and process for patients who may not wish to be photographed, recorded or participate in interviews, thus staff need to enquire about the patient's privacy needs related to care given.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Policy on consent for patient to be photographed, recorded or participate in interviews.	NA					

STANDARD 6.1.4

The Facility takes measures to protect patients' possessions from theft or loss. The Facility communicates its responsibility for the patient's personal possessions brought into the Facility. There is a process to account for the possessions and to ensure they will not be lost or stolen. This process considers the possessions of emergency patients, day surgery patients, inpatients, and those patients unable to make alternative safekeeping arrangements and those incapable of making decisions regarding their possessions, including those brought in dead.

CRITERION NO.	CRITERIA FOR COMPLIANCE			SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
6.1.4.1 CORE	The Facility has a policy that indicates its responsibility for patient's possessions and a system to ensure this policy is complied with.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Policy on patients possessions and records	NA					
	2.	On-site observation on compliance with the above policy.	NA					
6.1.4.2	Patients receive information about the Facility's responsibility for safe keeping and protecting personal belongings.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Orientation checklist and patient/relatives acknowledgement	NA					
6.1.4.3	Patients' possessions are safeguarded when the Facility assumes responsibility or when a patient is unable to assume responsibility.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Policy on patients' possessions and records	NA					
	2.	On-site observation on compliance to the policy	NA					

STANDARD 6.1.5

The Facility is responsible for protecting patients from physical injury by outsiders, other patients and staff and patient who are at risk of injuring themselves. Their responsibility is particularly relevant to infants and children, the elderly, disabled individuals, and others at risk. The Facility seeks to prevent injuries through processes such as screening individuals entering the Facility who have no proper identification and monitoring isolated areas of the Facility, as well as being responsive to those thought to be at risk of injury.

CRITERION NO.	CRITERIA FOR COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
6.1.5.1	The Facility has a policy on risk identification and implementation of safety measures to protect patients from injury.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Policy on risk identification	NA				
	2.	Risk identification strategies, e.g. security guard, closed-circuit television (CCTV), fall prevention, schedule of visiting hours and after visiting hours, passes for visitors, etc.	NA				
6.1.5.2 CORE	Infants, children, the elderly, disabled individuals, and others at risk are addressed in the process as in 6.1.5.1.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Policy on accompanying relatives	NA				
	2.	Evidence of compliance to the policy on risk identification.	NA				
	3.	Standard operating procedures on handling of high risk patients.	NA				
	4.	Register of visitors after visiting hours for high risk wards/areas.	NA				
6.1.5.3	Individuals without identification are screened.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Policy on management of individual without identification	NA				
	2.	Facilities for monitoring of high risk/suspected intruders, e.g. security/static guard, CCTV, etc.	NA				
6.1.5.4 CORE	Remote and isolated areas of the Facility are monitored.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Availability of monitoring facilities in remote and isolated areas.	NA				
	2.	Records on monitoring/surveillance reports	NA				

STANDARD 6.1.6

Children, disabled individuals, the elderly and other population at risk receive appropriate protection. Comatose patients and individuals with mental or emotional disabilities are included. Such protection extends beyond physical injury to other areas of safety such as protection from abuse, negligent care, withholding of services or assistance in the event of an evacuation.

CRITERION NO.	CRITERIA FOR COMPLIANCE			SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
6.1.6.1	Children, disabled individuals, the elderly and others identified as vulnerable group are protected from abuse, negligent care, withholding of services or assistance in the event of an evacuation and overall safety of the patients is ensured.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Policy on protection for children, disabled individuals, the elderly, and others identified as vulnerable group.	NA					
	2.	Standard operating procedures for evacuation of the above group during emergencies.	NA					
6.1.6.2	Special attention and priority care are given to children, disabled individuals, the elderly, individuals with mental and emotional disabilities and other vulnerable groups.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Policy on provision of priority care for children, disabled individuals, the elderly, individuals with mental and emotional disabilities and other vulnerable groups.	NA					
	2.	Orientation for family members and checklists.	NA					
	3.	Special amenities provided to meet the needs of the above group, e.g. special lane, disabled friendly toilets, children's toilets and sink, OKU parking lots with accessibility to wheelchairs, etc.	NA					
	4.	On-site observation on compliance to policy for priority care.	NA					
6.1.6.3	Staff including medical practitioners understand and implement their responsibilities in the protection processes of patients.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Records of orientation/training for in-house staff on the policy.	NA					
	2.	On-site observation on practices	NA					

STANDARD 6.1.7

Patient information is kept confidential. Medical and other health information which may be in paper or electronic form or in the combination of both shall be treated as confidential. There are policies and procedures that protect such information by laws from misuse. The policies and procedures also reflect information that is released as required by laws and regulations.

CRITERION NO.	CRITERIA FOR COMPLIANCE			SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
6.1.7.1	Patients are informed about laws and regulations that require the release of and the confidentiality of patient information.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Policy on release of patient information.	NA					
	2.	Patient orientation checklist	NA					
6.1.7.2	Patients are required to grant permission for the release of information not covered by laws and regulations.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Signed consent form on release of patient information.	NA					
6.1.7.3	There is a policy to identify those eligible to receive patient information.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Policy on release of patient information	NA					
	2.	Consent form/authorisation letter	NA					
6.1.7.4 CORE	The Facility ensures patient health information as confidential.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Policy on safeguarding of patient information	NA					
	2.	Policy on release of patient's medical record.	NA					
	3.	Code of conduct of medical records staff	NA					
	4.	Secured health information system with restricted access levels	NA					
	5.	Restricted access to Medical Records Unit	NA					
	6.	System for recording and monitoring movement of medical records.	NA					

	7.	Computer-on-wheel/tablets, etc. should be automatically shut- down after 3 minutes when not in used. (should have crossed - reference to Standard 7)	NA					
	8.	Policy on no photograph EMR/hardcopy record	NA					

STANDARD 6.1.8

The Facility supports patients' and families' rights to participate in the care process. Patients and families participate in the care process by making decisions about care, asking questions about care, and even refusing diagnostic procedures and treatment.

CRITERION NO.	CRITERIA FOR COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
6.1.8.1	Policies and procedures are developed to support and promote patient and family in care processes including information on medical condition, confirmed diagnosis, planned care and treatment.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Policy on patient participation in their care and treatment.	NA				
6.1.8.2 CORE	Patient and the family are informed about the outcomes of care and treatment, including where appropriate the unanticipated outcomes.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Interview of patient	NA				
	2.	Documentation in the medical records	NA				
	3.	Consent form where applicable	NA				
6.1.8.3	Patients are informed about their rights and responsibilities related to refusing or discontinuing treatment and seeking a second opinion. Patient's refusal shall be acknowledged, respected and patient well-being is assured.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Interview of patient	NA				
	2.	Orientation checklist	NA				
	3.	Documentation in the medical records of the patient’s decision, e.g. At Own Risk (AOR) discharge form, refusal form, etc.	NA				
6.1.8.4	Staff including medical practitioners are trained on the policies and procedures on their roles and responsibilities in supporting patient and family participation in the care processes.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Staff orientation/training records	NA				

	2.	Minutes of meeting	NA					

STANDARD 6.1.9

The Facility respects patient's and family's wishes and preferences to withhold resuscitative services within ethical standards.

CRITERION NO.	CRITERIA FOR COMPLIANCE			SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
6.1.9.1	The Facility has an Ethical Committee which documents a policy on withholding resuscitative services that conforms to patients' beliefs, religion, and any legal or regulatory requirements.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Policy on withholding resuscitation	NA					
	2.	Minutes of Ethical Committee meeting	NA					
	3.	Agenda on Ethics in one of the Facility's committee meeting (non-specialist facility)	NA					
6.1.9.2	The Facility guides the healthcare professional on the ethical and legal issues in carrying out patient's wishes on withholding resuscitative services in timely manner.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Policy on withholding resuscitation	NA					
6.1.9.3	There is documentation about decisions made for withholding resuscitative services.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Documentation in medical records	NA					
	2.	Do Not Resuscitate Consent Form	NA					

STANDARD 6.1.10

The Facility supports the patient's rights to appropriate assessment and management of symptoms that could have adverse physical and psychological effects.

CRITERION NO.	CRITERIA FOR COMPLIANCE			SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
6.1.10.1	The Facility supports the patient rights to appropriate assessment and management of symptoms.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Assessment and care plan records.	NA					
6.1.10.2	Staff including medical practitioners understand the implications of the patient's report of symptoms and accurately assess and manage the symptoms.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Assessment and care plan records	NA					
	2.	Evidence of continuity of care in medical records, including history taking, physical examination, investigations, appropriate treatment given, etc.	NA					
	3.	Adherence to the treatment/ care plan e.g. patient’s note, nursing note, lab results, etc	NA					

STANDARD 6.1.11

The Facility supports the patient's right to humane, respectful and compassionate care at the end of life. Concern for the patient's comfort and dignity during the final stages of life guides all aspects of care. These include treatment of primary and secondary symptoms, pain management, psychological, social, emotional and religious needs.

CRITERION NO.	CRITERIA FOR COMPLIANCE			SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
6.1.11.1	The Facility recognises and manages the needs of dying patients.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Policy on end of life care.	NA					
6.1.11.2	Staff including medical practitioners respect and ensure the rights of dying patients to have those needs addressed in the care process.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Staff orientation	NA					
	2.	Availability of contact number/person of respective religious beliefs/support centres	NA					

STANDARD 6.1.12

The Facility informs patients and families about its grievance mechanism to receive and act on complaints, conflicts and differences of opinion about care and the patient's right to participate in these processes.

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
6.1.12.1 CORE	There is evidence that patients are informed of their rights to voice their complaints and the process to do so. EVIDENCE OF COMPLIANCE 1. Policy on grievance mechanism — NA 2. Patient orientation checklist — NA 3. Patient Charter — NA 4. Brochure on Patient and Family Rights — NA	NA			NA	
6.1.12.2	There is documented evidence that complaints are reviewed according to the Facility's grievance mechanism and policy, which include: a) designation of a patient relations officer; b) job description of the patient relations officer; c) decision-making authority given to the patient relations officer; d) how the patient relations officer may be contacted; e) information in the structured orientation programme; f) documentation and revision of all complaints. EVIDENCE OF COMPLIANCE 1. Appointment letter of patient relations officer — NA 2. Job description — NA 3. Facility directory – contact person to address complaint — NA 4. Patient orientation checklist — NA 5. Records of complaints — NA	NA			NA	
6.1.12.3	There is documented procedure to address all grievances which include: a) all complaints received are forwarded to the patient relations officer; b) results of the investigations are communicated to the complainant within ten (10) working days. EVIDENCE OF COMPLIANCE	NA			NA	

	1.	Flow chart on grievances mechanism	NA					
	2.	Acknowledgement to complainant upon receipt of complaint.	NA					
	3.	Results of the investigations are communicated to the complainant within ten (10) working days	NA					
6.1.12.4	There are documented policies and procedures to identify how the patients and families participate in the grievance process.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Policies and procedures on participation of patients and families in the grievance process.	NA					

STANDARD 6.1.13

CONTINUITY OF CARE

There is evidence of implementation of the policy on patient's continuity of care including after discharge care.

CRITERION NO.	CRITERIA FOR COMPLIANCE			SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
6.1.13.1 CORE	The Facility ensures that the patient's right to continuity of care is implemented.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Policy on after discharge care/follow up care	NA					
	2.	Appointment system for follow up care	NA					
	3.	Home visit where applicable	NA					
	4.	Brochure/leaflet on extended care	NA					

STANDARD 6.1.14

PATIENT AND FAMILY EDUCATION

The Facility provides an education program that is based on its mission, services provided and patient population and health care practitioners collaborate to provide education. It will involve all department /units.

CRITERION NO.	CRITERIA FOR COMPLIANCE			SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
6.1.14.1	1. Patient's and family's barriers to learning are assessed and documented. 2.Education by facility staff is provided to patients and families in a manner that accommodates their identified needs			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Education provided to patients and families is documented in the patient medical record	NA					
	2.	Educational pamphlets are developed and is accessible to all	NA					
	3.	There is a process to verify that patients and families receive and understand the education provided	NA					

TOPIC 6.2

INFORMED CONSENT

Patients and families are informed as to what tests, procedures and treatments require consent; and how they can give consent, and who may, in addition to the patient, give consent. The consent process is clearly defined and documented in policies and procedures. Relevant laws and regulations are incorporated into the policies and procedures.

STANDARD 6.2.1

Patient's informed consent is obtained through a process defined by the Facility and carried out by trained medical practitioners.

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
6.2.1.1 CORE	There are documented policies and procedures that clearly: a) define informed consent which include the following elements: i) patient's condition ii) proposed treatment (s) or procedure (s) iii) name of the person providing the treatment/procedure iv) potential benefits and drawbacks v) possible alternatives vi) likelihood of success vii) possible problems related to recovery viii) possible results of non treatment b) outline the procedures for obtaining it. Written consent is obtained from: i) the patient; ii) the spouse, parent or next of kin where the patient is mentally disabled; iii) the parent or guardian where the patient is unmarried and below eighteen (18) years of age. EVIDENCE OF COMPLIANCE 1. Policy on informed consent without abbreviation — NA 2. Standard Operating Procedures (SOP) on obtaining consent — NA 3. Signed consent forms — NA	NA			NA	
6.2.1.2	Consent may be dispensed with according to the relevant laws where any delay caused in obtaining the consent would endanger the life of a patient, provided that a consensus of two (2) medical practitioners is obtained and they jointly sign a statement stating that the delay would endanger the life of the patient. EVIDENCE OF COMPLIANCE	NA			NA	

	1.	Policy on obtaining consent for life threatening cases that need immediate intervention	NA				
6.2.1.3 CORE	Informed consent is obtained before surgery, anesthesia, the use of blood and blood products, procedure sedation, and other high-risk treatments and procedures, and the information given shall be documented in the medical records.			NA		NA	
	EVIDENCE OF COMPLIANCE						
	1.	Signed consent forms. (The procedure is only performed after the consent taken.)	NA				
	2.	Documentation in medical records (explanation given at the time of taking consent)	NA				
	3.	Validity of the signed consent form is 30 days	NA				
6.2.1.4	There is a list in the Facility of all types of treatments and procedures that require informed consent.			NA		NA	
	EVIDENCE OF COMPLIANCE						
	1.	Approved list of all types of treatments and procedures that require informed consent.	NA				
6.2.1.5	Informed consent is obtained from the patient or family member where applicable by the medical practitioner responsible for the procedures/treatment and risks and complications have been explained to the patient or family members.			NA		NA	
	EVIDENCE OF COMPLIANCE						
	1.	Consent form signed by patient or family member and medical practitioner responsible for the procedures/treatment.	NA				
	2.	Interview of patient as observed on-site.	NA				
	3.	Documentation in medical records (explanation of risks and complications to the patient or family members.)	NA				

TOPIC 6.3:

RESEARCH

A Facility that conducts research, investigations, or clinical trials involving human subjects has a responsibility to the patient's health and well- being. Patients and families will be provided with the following information:

a) expected benefits;
b) potential risks and complications;
c) procedures that shall be followed.

All research proposals that involve multicenter trials shall be approved by the Ministry of Health's Medical Research and Ethics Committee.

STANDARD 6.3.1

A Facility that conducts research, investigations, or clinical trials involving human subjects has a responsibility to the patient's health and well- being.

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
6.3.1.1	There is a committee with documented Terms of Reference to oversee all research conducted in the Facility involving human subjects. **EVIDENCE OF COMPLIANCE** 1. Establishment of Research Committee — NA 2. Term of Reference — NA 3. Minutes of meetings — NA	NA			NA	
6.3.1.2	The Facility has policies, procedures, and a code of ethics for the selection and participation of patients in clinical research, investigations, or clinical trials. **EVIDENCE OF COMPLIANCE** 1. Policies and procedures for selection and participation of patients in clinical research, investigation or clinical trials. — NA 2. Code of Ethics — NA	NA			NA	
6.3.1.3	The Facility informs patients and families in advance about: a) research procedures; b) risks and benefits; c) obtaining inform consent; d) withdrawal from participation; e) suspension or termination of the research.	NA			NA	

	EVIDENCE OF COMPLIANCE						
	1.	Documentation of (a) to (e) in the patients' medical records	NA				
	2.	Samples of patients' participation forms.	NA				
6.3.1.4	Outcomes of patients who choose to participate in clinical research, investigations, or clinical trials are constantly reviewed to protect their well-being and health.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Periodical report of clinical research related to outcomes of trials.	NA				
	2.	Medical records of participating patients.	NA				
6.3.1.5	Informed consent is obtained before the patient participates in clinical research, investigations, or clinical trials.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Samples of consent forms from participating patients. The informed consent should be taken before the patients participate in the clinical trials.	NA				

TOPIC 6.4:
ORGAN, TISSUE AND CELL DONATION
The Facility supports the decision of patients and families to donate organs, tissues and other cell for research or transplantation. Relevant staff of the Facility are made known of policies and procedures on procurement, donation process and the transplantation of organs, tissues and cell.

STANDARD 6.4.1
Policies and procedures are available to guide the procurement, donation process and the transplantation of organs, tissues and cell. Policies are consistent with relevant laws and regulations and respect the community values, beliefs and religion.

CRITERION NO.	CRITERIA FOR COMPLIANCE			SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
6.4.1.1	The Facility provides relevant information on the procurement, donation process and transplantation process.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Policy on organ/tissue/cell procurement, donation process and transplantation process (National Policy on Organ Transplantation, Ministry of Health)	NA					
	2.	Availability of pamphlets on donation and transplantation of organ.	NA					
6.4.1.2	There are policies and procedures available to guide the procurement, donation process, and transplantation of organs/tissue/cells, consistent with relevant laws and regulations, and respecting the individual's values, beliefs, and religion.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Standard operating procedures for procurement, donation process and the transplantation of organs/tissues/cell (National Policy on Organ Transplantation, Ministry of Health)	NA					
6.4.1.3 CORE	Staff are trained in the policies and procedures on organ/tissues/cell donation and transplantation.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Availability of trained staff to facilitate the organ, tissue and cell donation and transplantation.	NA					
	2.	Staff training records (not less than 20 hours) and certification	NA					

6.4.1.4	The Facility cooperates with other facilities or agencies responsible for all or a part of the procurement, banking, transportation, and transplantation process.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Policy on coordination with relevant agencies responsible for all or a part of the procurement, banking, transportation, and transplantation process.	NA					
	2.	Staff training log book records	NA					

TOPIC 6.5:
CONSUMER -CENTRED CARE

Healthcare service delivery shall focus on intra and cross departmental interactions between individual patients and health care providers. The service arrangements provide opportunity to respond to the inherent complexity of patient's health problems to deliver holistic and needs-focused services. Systems that evolve to embrace coordination of services to be better equipped to respond to these needs.

STANDARD 6.5.1

The Facility shall make health care systems more responsive to people's needs, while recognising their rights and responsibilities with regard to their own health to promote coordination of health services within the Facility and inter-services collaboration in order to address the patient's multiple co-morbidities and to ensure a holistic approach to patients, including health promotion, disease prevention, diagnosis, treatment, disease- management, rehabilitation and palliative care services.

CRITERION NO.	CRITERIA FOR COMPLIANCE			SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
						AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
6.5.1.1	There shall be inter-services coordination of care for patients with multiple co-morbidities through the alignment and harmonizing of the processes of the different services.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Cross departmental policy on case management	NA					
6.5.1.2	The Facility ensures effective and efficient coordination for patients requiring multidisciplinary care, which includes: a) Transparent, accessible, and understandable service protocols that improve interdisciplinary patient flow. b) Appropriate scheduling of appointments. c) Reminder notices for specific interventions. d) Protocols for referral and discharge as well as patient's/family's involvement.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Protocols for referral to multidisciplinary team	NA					
	2.	Records on multidisciplinary discussion/patients' related medical records	NA					
	3.	Records of patients' notices/reminders	NA					
	4.	There is documentation of patient /family involvement in the discharge / referral process	NA					

	5.	On-site observation on compliance with protocols for interdisciplinary referral and discharge.	NA					

SERVICE SUMMARY	
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OVERALL RATING :	NA
OVERALL RISK :	-