SIBUHOSPITAL

WHOLE HOSPITAL POLICY

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CONTENTS

1. INTRODUCTION

Sibu Hospital is one of the major specialist hospitals in Ministry of Health and is the second largest hospital in Sarawak. Sibu Hospital serves as the secondary referral centre for Central Sarawak, which includes 5 divisions i.e. Sibu, Kapit, Mukah, Sarikei and Betong. It receives referrals of patients from 8 district hospitals: Kanowit, Kapit, Mukah, Dalat, Daro, Sarikei, Saratok and Betong. In addition, some urgent cases from Bintulu Hospital of Bintulu division are also transferred to Sibu Hospital for further assessment and management due to its convenient geographical location.

1.1 Vision And Mission

1.1.1 Ministry Of Health

a. Vision For Health

A nation working together for better health

b. Mission

The mission of the Ministry of Health is to lead and work in partnership:

i. To facilitate and support the people to:

- attain fully their potential in health
- appreciate health as a valuable asset
- take individual responsibility and positive action for their health.

ii. To ensure a high quality health system that is:

- customer centered
- equitable
- affordable
- efficient
- technologically appropriate
- environmentally adaptable
- innovative

iii. With emphasis on:

- professionalism, caring and teamwork values
- respect for human dignity
- community participation

1.1.2 Sibu Hospital

a. Vision

Sibu Hospital shall be a centre of excellence in health & medical care.

b. Mission

Provide quality services through caring, teamwork and professionalism to meet the needs and expectation of all clients

c. Objectives

i. To provide diagnostic, curative, promotional and rehabilitative services that are appropriate, adequate, comfortable, effective, efficient and of the highest possible quality to patients in order to preserve life, reduce suffering and achieve early and maximum recovery.
ii. To provide quality patient oriented service based on humanistic values emphasing customer satisfaction
iii. To instill excellent work culture and to create a conducive environment to deliver quality services;
iv. To establish Sibu Hospital as a clinical teaching &research centre.

d. Roles And Activities

i. Provider of secondary medical care
ii. Undergraduate Medical Student training centre by MOU with University Malaysia Sarawak (UNIMAS)
iii. Training centre for Houseman
iv. Postgraduate training centre for Ministry Of Health
v. Training centre for basic nursing, physiotherapy, laboratory, radiology for various colleges

1.2. SCOPE OF SERVICES

1.2.1 Clinical Services

The hospital clinical service is provided through inpatient wards and outpatient clinics. The clinical services include:

- Emergency and Trauma service
- General Medicine
- Rheumatology
- General Surgery
- Neurosurgery
- General Paediatrics
- Obstetrics & Gynaecology
- Orthopaedics
- Ophthalmology
- Ear Nose &Throat
- Psychiatry
- Anaesthetic Service
- Operating Suite Service
- Ambulatory Care Service
- Critical Care Service: Intensive Care, Neonatology
- Labour / Delivery Service
- Specialist Outpatient Clinics

1.2.2 Clinical Supporting Services

- Diagnostic imaging services
- Pathology Services
- Blood Transfusion Services
- Pharmacy Services
- Physiotherapy,
- Occupational Therapy
- Medical Social Welfare
- Medical Counseling
- Environmental Health
- Central Sterile Supplies
- Dietary &Catering services
- Mortuary and Forensic services

1.2.3 Hospital Support Service (outsourced)

2 ORGANIZATION & MANAGEMENT

2.1 Hospital Director

The Hospital Director is responsible for the overall management of the hospital, supported by the heads of the clinical and non-clinical departments/units of the hospital.

2.2 Heads of Departments

The Hospital Director shall appoint the Heads of all clinical & non-clinical departments based on their posts, training & capability.

2.3 Hospital Management

The hospital management is assisted & coordinated by various management & advisory committees of the hospital such as Hospital Management Committee, Medical Advisory Committee, Hospital Privileging Committee, Hospital Safety Committee, Hospital Houseman Training Committee, Hospital Drugs Committee, Hospital Medical Records Committee, Infection Prevention &Control Committee, Operation Theatre Committee, Quality Committee, etc.

2.4 Management Matron

The Management Matron assisted by Area Matrons and Nursing Sisters shall manage all aspects of nursing services. She shall also be directly responsible for other services such as C.S.S.D, linen and laundry, nurse's hostel, cleanliness within wards, infection control, etc.

2.5 Chief Assistant Medical Officer

The Chief Assistant Medical Officer shall be responsible for coordinating the services provided by the assistant medical officers. In addition, he shall be directly responsible for services such as admission, ambulance service, facility & engineering management services, and fire safety.

2.6 A**dministrative Officers and Accountant**

The Administrative and Diplomatic Officers, Assistant Administrators, Accountant and Assistant Accountant shall manage the administrative department. They are responsible for general administration, human resource, finance and account, revenue collection, asset management etc. The head of Administrative Department shall also be responsible for coordinating the security services.

2.7 Hospital Support Services

The Hospital Support Services shall follow the agreed TRPI, the MAP and the HSIP for the five privatized services – Facility Engineering Maintenance Services, Biomedical Engineering Maintenance Services, Cleansing Services, Linen and Laundry Services and Clinical Waste Management Services. The services will be overseen by the Chief Assistant Medical Officer as the Chief Liaison Officer. He is assisted by the respective Liaison Officers in monitoring the works carried out by the Hospital Support Services.

2.8 Overall Organization

The overall organization of the hospital is shown on the chart in the following page.

3.0 CORPORATE GOVERNANCE

3.1 General Administration

3.1.1 Letters and Documents

i. The General Administration Unit shall be responsible for the management of all incoming and outgoing official letters;

ii. The hospital shall have a common and systematic hospital filing system of all official documents. Both incoming and outgoing letters shall be filed accordingly.

iii. Incoming letters/documents shall be registered, minuted and dispatched to the respective department/unit within specified time. Urgent letters shall be dispatched immediately and the respective department/unit informed by phone.

iv. All outgoing official letters shall use the standard letterhead of the hospital.

v. Letters for internal circulation shall be circulated as Memos.

vi. Letters/documents classified under the Official Secret Act shall be handled according to the requirement of the Act and kept in a separate file.

vii. Letters/documents shall be kept for the required number of years. Disposal of letters and documents shall be in accordance to the procedures and guidelines issued by National Archive Department *(Jabatan Arkib Negara).*

3.1.2 Office Equipment and Supplies

i. The Procurement Unit shall coordinate the requirement of office equipment e.g. stationeries of the hospital and distribution to units/departments.

ii. The department/unit head shall be responsible for maintaining the asset and inventory list and to ensure proper use of equipment and supplies.

iii. Certain office equipment shall be shared among several departments/units. Shared equipment shall be under the responsibility of the department/unit where the equipment is/are located.

iv. The "*Pekeliling Perbendaharaan Bil.5 Tahun 2007: Tatacara Pengurusan Aset Alih Kerajaan"* shall be adhered to. The hospital's Asset Management Unit / Committee shall be responsible for the following functions i.e. receiving, registering, usage, safekeeping, inspection, maintenance and disposal.

3.1.3 Meeting Room Facilities

i. The use of meeting rooms and various seminar rooms shall be coordinated. A designated person shall be responsible for coordinating these services.

ii. Meetings shall be well organized and documented. Call letters shall be sent out well in advance and minutes of meeting shall be sent out within specified time. A copy of the minutes shall be kept in the relevant file. Refer to *Pekeliling Kemajuan Pentadbiran Awam, Bil 2/1991 Arahan Perkhidmatan Bab 1-Bab 8.*

3.2 Finance

3.2.1 Allocation and Expenditure

i. Hospital fund shall be allocated according to Activity.

ii. The Head of the Activity shall be responsible for preparing the programme agreement, carry out evaluation and prepare exceptional report, if required, at the end of the budget year.

iii. The Head of the Activity shall be responsible for putting up justifications for additional budget.

iv. A Finance Committee shall be established to discuss financial and account issues including expenditure status, budget reallocation and additional requirement. The hospital director shall be fully responsible for the management of allocation and expenditure of the hospital.

3.2.2 Procurement

i. Procurement of hospital supplies or specific items shall be coordinated by Procurement Unit.

ii. The procurement process include activation of 5 various committees i.e. Specification, Opening, Technical, Cost Evaluation and Selection. The Hospital Management Committee shall establish a system that is transparent to ensure that the procurement process is carried out in accordance to Treasury Instructions.

iii. Refer to *Arahan Perbendaharaan Bab A-Bab C.*

3.2.3 Claims and loans

i. Staff shall be required to submit claims within the first ten days of the following month. It shall be completed, signed and attached with the necessary documents.

ii. Head of department/unit shall be responsible for verifying and validating the claims before submitting to the Finance Unit.

iii. Government loan application shall be submitted based on eligibility and attached with the necessary forms and document.

iv. Refer to *Elaundan Kemudahan Perkhidmatan Awam, Bahagian Saraan JPA 2012* at jpa.gov.my

3.3 Revenue Collection (Hospital revenue)

3.3.1 Hospital Charges

i. Fees shall be charged in accordance to the Fee Order (Medical) 1982, Fee Order (Medical) (Amendment) (Foreigner) 2003, Fee Order (Medical) (Full Paying Patient) 2007 and the MOH Finance circulars. Procedures not listed in the Fee Order shall be forwarded to the Finance Division of MOH for approval of fee. The hospital shall make available the information on hospitals fees/charges to all parties.

ii. Deposit shall be collected prior to admission with the exception of emergency cases where deposit may be collected later.

iii. Hospitals shall take all possible measures to collect payment from patients.

iv. Exemption of payment to certain group of patients for example the Orang Asli or individuals may be exercised according to the Treasury Instruction/ MOH Circulars and Fee Order (Medical) 1982

v. Refer to (i) Fee Order (Medical) 1982, (*Jadual A Caj Pesakit Luar, Pengecualian)* and (ii) *Akta Acara Kewangan* (iii) *Surat Pekeliling Bahagian Kewangan Bilangan 2 Tahun 2012 Pelaksanaan Pengecualian Caj Pendaftaran Jabatan Pesakit Luar Pakar sebanyak RM5.00 dan Pengurangan Caj sebanyak 50% bagi Pesakit Kelas 3 di Hospital/Klinik Kementerian Kesihatan Malaysia kepada Semua Pesakit Warganegara yang Berumur 60 tahun dan Keatas*.

3.3.2 Billing & Payment

i. For paying patient, the hospital bill shall be given upon discharge and they are required to settle the bill at the revenue counter before going home. Interim bill maybe given 1 day prior to discharge. Long staying patient maybe informed of their accumulated bill at intervals.

ii. For patients with valid Guarantee Letter on admission, Hospital bills shall be sent to the employer. Revenue unit staffs shall refer to the electronic Guarantee Letter (eGL) for civil servants and their dependents.

iii. The hospital shall receive payment in cash, money order, postal order, bankers' cheque or credit/debit card. Personal cheques are not accepted. Receipts shall be issued upon payment.

iv. Revenue collection shall be carried out by authorised personnel at a designated revenue counter.

3.4 Human resource

3.4.1 Human Resource Planning

The hospital management shall ensure there are systems to provide appropriate numbers of people with required skills are made available in the hospital. The hospital management is responsible for human resource training in accordance to service needs and expansion plan.

3.4.1.1 Orientation

i. Newly appointed Staff shall be informed about the terms and conditions of appointment as in the General Order and PKPA (*Perintah-Perintah Am) Peraturan-peraturan Pegawai Awam (Perlantikan, Kenaikan Pangkatdan Penamatan Perkhidmatan)*

ii. Orientation programme shall be organized for all new staff which includes overall briefing on the hospital policies, procedures, rules and regulation and their roles and responsibilities.

iii. Specific briefing shall be given by the departments and units.

3.4.1.2 Placement

i. Placement of staff to departments or units shall be based on qualification, specialized training received and service needs.

ii. The department/unit head shall be responsible for the placement and job description within the department/unit.

iii. Deployment and rotation of staff to other department and unit may be carried out as and when necessary.

iv. Refer to: (i) *SPKPK Bil.4/2005 Penempatan Secara Bergiliran (Rotational Posting) bagi Pegawai Perubatan di Hospital dan Klinik Kesihatan Malaysia* dated 20 July 2005, (ii) *SPKPK Bil.4/2010 Garispanduan Bertugas atas Panggilan Untuk Pegawai Perubatan dan Pegawai Perubatan Siswazah di Hospital-hospital KKM*dated 12 March 2010),and(iii) *Buku Panduan Program Pegawai Perubatan Siswazah, Edisi 2012, KKM*

3.4.1.3 Work Attendance and Leave

i. Staff shall record their daily attendance and movements within working hours using the appropriate person attendance system e.g. punch card, record book, access card, special forms etc. Staff requesting for time-off during office hours shall complete the form (*Kebenaran Untuk Meninggalkan Pejabat Dalam Waktu Bekerja Di bawah Perintah Am 5 Bab G: Borang Permohonan Kebenaran Meninggalkan Pejabat Dalam Waktu Bekerja)*

ii. Department/unit head shall be responsible for monitoring their staff daily attendance/movement.

iii. Staff shall submit leave in advance before taking leave. They shall make sure the leave has been approved before taking the leave.

iv. Staff shall inform their department/unit head if they are not well to be present at work and/or has been given Sick Certificates.

v. Staff participating in Medical And Humanitarian Aid Mission shall be accorded a maximum of 21 day non-recorded leave (including weekends and holidays), when the mission is organized by a recognized body as stated in the *Perintah Am 42(a) Bab C.*

3.4.1.3 Staff Safety

a. All safety measures stated in the existing MOH guidelines shall be adhered to.

b. All departments shall identify additional specific safety precautions for their work areas and ensure that their staff observe these safety measures.

c. All staff shall observe standard precautions where appropriate.

3.4.1.4 Staff Welfare

a. Priority in allocating hospital quarters is given to staff who are on-call.

b. Separate vehicle parking areas are made available for the staff where possible.

c. Space for recreational facilities and outdoor activities are available for staff.

d. Staff is encouraged to establish a social, sports and welfare society to promote goodwill and establish closer ties among staff.

e. Staff rest rooms and Muslims prayer rooms are provided.

f. Lockers are provided for staff use in specific areas.

g. Staff Clinic is provided for staff and immediate family members. It shall be run on at least half daily basis except in situation of shortage of doctor.

3.4.1.5 Staff Discipline

a. Staff should internalize the MOH corporate values of teamwork, caring and professionalism at all times.

b. Staff should observe relevant professional codes of ethics

c. The Public Officers Regulations (Conduct and Discipline), 1993 are adhered to.

d. Staff who is required to wear uniform shall be in uniform while on duty.

e. Name tags shall be worn while on duty.

f. Staff shall not smoke within the hospital ground.

g. All staff should comply with the Client's Charter at all times.

h. Staff are not allowed to be involved in any business including hawking, soliciting and touting within the hospital premises.

i. Gifts received should be in accordance with existing guidelines.Adhere to *Pekeliling Perkhidmatan Bilangan 3 Tahun 1998 Garis Panduan Pemberian Dan Penerimaa Hadiah Di Dalam Perkhidmatan Awam; Akta 694 Akta Suruhanjaya Pencegahan Rasuah Malaysia 2009.*

j. Refer to: (i) *Perintah-Perintah Am, (ii) SPKPK Bil.1/2000 Amalan Etika Profesion Perubatan Yang Baik* dated 26 May 2000, (iii) *SPKPK Bil.4/1989 Kod Pakaian Untuk Doktor* dated 26 October 1989, and (iv) *SPKPK Bil.3/1987 Penyeliaan Doktor-doktor Di Jabatan Klinikal* dated 6 April 1987)

3.4.1.6 Staff Appraisal

a. Every staff shall have a '*fail meja*' which contain the job description, responsibilities and related work guidelines and procedures.

b. Staff in consultation with respective Heads of Department shall prepare the Annual Work Targets (*Sasaran Kerja Tahunan*) and indicators e.g. Key Performance Indicators for measuring achievement at the beginning of the year.

c. Staff should be appraised by respective heads on a 6-monthly basis based on the agreed performance indicators in the Annual Work Targets.

d. Appraisal should be done as objective and transparent as possible.

3.5 Transport Services

3.5.1 General Transport System and Ambulances

i. The hospital shall provide ambulance services for patient and public and transportation for both patients and staff. Ambulances and vehicles shall be well maintained and ready for use at all times.

ii. Hospital vehicles shall be used for specified purpose as follows:
- Ambulances shall be used for pre-hospital care and for inter-hospital transportation of patients.
- Hearses shall be used for the transportation of dead bodies.
- Vans shall be used to transport supplies and materials.
- Saloon cars shall be used to transport staff.

iii. Hospital vehicles shall be driven by hospital drivers with valid driving licenses and shall abide to the road traffic rules and regulation at all times.

iv. The ambulances shall be under the responsibility of the Emergency Department whilst the other vehicles will be by the Administration Unit. The

number and type of vehicles supplied shall conform to the norms of the Ministry of Health.

v. Relatives are not allowed to accompany patients in the ambulance and are required to sign an indemnity form if they do. However, parents shall accompany pediatrics patients.

vi. The occupancy of the vehicle shall be in accordance with the manual of each type of vehicle.

vii. The usage of the appropriate transport during emergency is under the discretion of the Hospital Director.

viii. The logbook of all vehicles and ambulances shall be updated regularly.

ix. Drivers shall ensure regular cleaning of the vehicles and ambulances.

x. Refer to*: (i) SPKPK Bil.6/2007 GarisPanduan Latihan Pemanduan Ambulan KKM,* dated 16 July 2007

xi. The provided hearse services are subjected to the availability of hearse vehicles, drivers, road access/condition, day and time.

xii. Charges for the use of hospital transport by patient other than ambulance call shall be in accordance with the Fees (Medical) Act 1982.

3.5.2 Porter Service

The function shall be carried out by ward attendants of specific wards/areas.

Ward attendants who are under the matron provide pottering services. They shall be responsible for routine functions such as:

i. dispatching routine laboratory specimens and delivering clean specimen containers and laboratory test results
ii. delivering X-ray films
iii. transferring records between the Medical Records Department and the wards and specialist clinics
iv. delivering stationary and mails
v. dispatching charge sheets, indents, etc.
vi. delivering food and collecting the utensils and leftovers (kitchen)
vii. delivering supplies (pharmacy and pharmacy store)
viii. delivering clean and collect used CSSD packs (CSSD)

ix. As for urgently needed supplies, department staff is responsible for collecting them from respective stores:

- medical supplies from the medical store;
- domestic and office supplies and stationery from administration store (Dry store);
- food supplies from the kitchen.

3.6 Visiting Hours

3.6.1 General

i. Visiting hours of the hospital is as follows:

Weekdays
12.30 pm - 2.00 pm 4.30 pm - 7.30 pm
Saturday, Sunday and public holidays
12.30 pm – 7.30 pm

ii. During visiting hours, relatives shall be allowed to visit patients in the general wards.

iii. Visit to the critical care areas shall be restricted to two visitors per patient at any time.

iv. Children aged below 12 shall not be allowed to visit patients in the critical care areas and isolation rooms.

v. Special approval can only be granted by Nursing Sister of the respective ward for relatives coming from far and who may not be able to visit their relatives during specified visiting times.

3.6.2 Outside Visiting Hours

i. Number of visitors shall be restricted after visiting hours to only 2 visitors per patient at a time. This is inclusive of the one approved accompanying the patient. Two passes will be issued per patient. After visiting hours any visit shall not exceed more than half an hour. All visits after visiting hours shall be recorded.

ii. One relative per adult patient is allowed to accompany patient in Medical, Surgical, Orthopaedics and EENT wards.

iii. Approval will also be granted for the following situation:

- Relatives to accompany critically ill and bed ridden patients. Only female relative shall be allowed to accompany patient in the female ward/cubicle.
- Mothers or guardians to accompany children in the pediatric wards.
- Mothers rooming-in with babies admitted to the special care nursery for breastfeeding.
- Relatives under the Mother Friendly Care and Husband Friendly Care initiatives.
- The security and privacy of the patients is not threatened.

iv. No visitor shall be allowed to stay with the patient in Intensive Care Unit. However, for Glasgow Coma Scale assessment, in the presence of language barrier between staff and patient, family members will be allowed to enter other than the visiting hours to assist.

3.6.3 Other Hospital Visitors

i. Registered hospital volunteers shall be allowed to enter the hospital up to 9.00 pm

ii. Members of the Board of Visitors with identification cards may be allowed to enter the hospital at anytime for formal duties.

iii. VIPs on official visit shall be accompanied by the hospital staff.

iv. Family members are allowed entry to pay last visit for dying patient. A special pass will be given to the family.

v. Members of Women's Breastfeeding Support Group with identification cards may be allowed to enter the hospital to assist mothers with breastfeeding support and perform format breastfeeding related activities at Paeds. & O&G department

3.7Traffic Control

i. The hospital shall implement a traffic system within the hospital to avoid traffic congestion. Road to the Emergency and Trauma Department (ETD) shall only be used by ambulances and public/private vehicles bringing emergency cases, for exit and entry.

ii. Drop-off and pick-up zone shall be provided near the entrance to the One-Stop Service counter/ ETD/ Hospital main lobby - Labour Room for patients' convenience.

iii. Refer to: *SPKPK Bil.10/2004 Garispanduan Mengenai Peraturan Lalu lintas dan Meletak Kenderaan di Hospital-hospital KKM* dated 15 December 2004

3.8 HOSPITAL SECURITY

3.8.1 The Hospital Management Committee and management meetings.

The Hospital Management Committee under the leadership of the Hospital Director shall ensure that effective and efficient security system is in the hospital. Security matter shall be a regular feature on the agendas of all management meetings.

3.8.2 Coordinator

The Assistant Hospital Director (Management) shall be the coordinator for security service.

3.8.3 Patrols by security guards.

Security services for the hospital grounds shall be privatized. Regular compound patrols and patrols within the hospital complex shall be undertaken by the security guards.

3.8.4 "Garispanduan Sistem Keselamatan Pesakit Dan Harta Kerajaan Di Hospital".

The Ministry of Health's "Garispanduan Sistem Keselamatan Pesakit Dan Harta Kerajaan Di Hospital" shall be complied with. The hospital shall adapt these guidelines for its use.

iii. R*efer to: (i) SPKPK Bil.4/2006 Larangan Penggunaan Telefon Bimbit dan Telefon Selular di Hospital-hospital dan Institusi-institusi KKM dated 23 August 2006,(ii) SPKPK Bil.6/2005 Garispanduan Sistem Kawalan Keselamatan Bayi di Hospital-hospital KKM dated 1 September 2005,(iii) SPKPK Bil.14/2002 Garispanduan Sistem Kawalan Keselamatan di Hospital-hospital KKM dated 20 November 2002)*

3.8.5 Patients' valuables.

Patients are not encouraged to carry valuables with them when admitted. Patients shall be requested to make arrangements to send their valuables homes. However a small lockable drawer at the staff station shall be provided for temporary safe keeping of small items in the wards. For longer duration the items shall be transferred to the main safe at the Administration Department.

3.8.6 Security of baby

There must be security at the entrance of wards with baby to ensure all baby discharged have been double checked and documented. The*SPKPK Bil.6/2005*

Garispanduan Sistem Kawalan Keselamatan Bayi di Hospital-hospital KKM dated 1 September 2005 shall be complied with.

3.8.7 Revenue collection.

All revenue collected at all counters e.g. Payment Counter, Psychiatric Specialist Clinic, Occupational Therapy & Physiotherapy Departments and Emergency and Trauma Department shall be stored in a cash box in a locked drawer at respective reception counter. The cash is surrendered to the Revenue Unit of the Administration Department at the end of each working day to be kept in the main safe. During public holidays, the collection must be submitted to Administrative Department by noon.

3.8.8 Controlled drugs

Controlled drugs shall be stored in the Controlled Drugs Cupboards. Keys are to be kept by Nursing Sister, Staff Nurse in-charge, Senior Assistant Medical Officer or Assistant Medical Officer in-charge.

3.8.9 Master key system

A master key system shall be in operation. All keys, including lift door keys, shall be kept at the telephone operator room after office hours.

3.8.10 The medical records room

The medical records room shall have safety grills and fire proof doors and walls as security precautions.

3.8.11 Security in departments

Heads of department are expected to implement and observe relevant security measures in their departments at all time

3.8.12 Staff briefing and explanation to patients and visitors.

Staff shall be adequately oriented and briefed on all security measures to be implemented. Explanation also needed to be given to patients and visitors on the rules and regulations to be observed in the hospital.

3.8.13 Security of detainees and prisoners receiving treatment.

The police and prisons authorities are primarily responsible for security matters relating to detainees and prisoners receiving treatment in the hospital but the hospital management shall give full co-operation in providing the necessary facilities.

3.8.14 Visitors.

Visitors shall only be allowed into the wards during the specified visiting hours, except for those special cases with permission from Specialist, Medical Officer, Matron, Nursing Sister or Staff Nurse.

3.8.15 Spare keys

A set of spare keys into all departments shall be kept securely at the Administrative Department.

3.8.16 Special security precautions.

Special security precautions shall be observed in certain areas such as Medical Record Department, Maternity, SCN, Medical Store, Pharmacy and Psychiatric Unit.

3.9 Boards of Visitors

3.9.1 Hospital Board of Visitors

a. Members and period.
The hospital shall have a board of visitors with 9 to 18 members appointed for a period of 3 years

b. Function of the board of visitors
The hospital shall have a board of visitors with 9 to 18 members appointed for a period of 2 or 3 years.The board of visitors (BOV) shall function in accordance to the Ministry of Health's guidelines.Refer to*: SPKPK Bil. 2/1996 Insentif-insentif Bagi Ahli Lembaga Pelawat Hospital dated 6 July 1996* and *Surat Makluman Penyelarasan Insentif-insentif Bagi Ahli Lembaga Pelawat Hospital, 2009.*

c. The BOV shall act as a link between the hospital and the public and contribute in various ways to the hospital's programs such as hospital image, welfare program, etc.

d. Visits and meetings shall be held regularly (but not less than once in 3 months). Reports of visits and minutes of meetings shall be kept in the office, and copies forwarded to the State Director's office.

e. Board members shall be allowed to make visits to the wards and other public areas during or after office hours but must wear the identification pass. The board shall not visit restricted areas such as the operating theatre, delivery suite, CSSD, isolation rooms, medical store, etc. The hospital management shall take appropriate actions on the feedback received or issues raised by the Board.

f. The BOV may obtain information from patients regarding hospital facilities, food, clothing, cleanliness and services provided by the staff, but shall not discuss with patients the technicalities of the treatment provided nor examine the patients' case notes.

g. Board members shall be invited to attend hospital functions and activities including the relevant CME session.

h. Board members shall be invited as internal surveyor for Accreditation survey on "Patient and Family Rights".

3.9.2 Board of Visitors for Psychiatric Wards

i. The appointment of Board of Visitors for Psychiatric Hospitals by the Minister of Health shall consist of not more than 25 members.

ii. The members shall include at least 3 medical officers or Registered Medical Practitioners preferably a psychiatrist who does not work in that particular hospital. One of the doctors has to be female. The Board of Visitors shall consist of at least 3 female members.

3.9.3 Hospital Volunteers

i. Those who want to become hospital volunteers shall apply directly to the Hospital Director and shall follow the procedure required for approval.

ii. The administrative officer from the hospital is appointed as coordinator. This person will be in charge in guiding the volunteers for their job scope and monitoring their services.

iii. The hospital volunteer shall abide to the hospital rules and regulations, and shall render services in a professional manners.

iv. Refer to*: SPKPK Bil.7/1994 Garispanduan Perkhidmatan Sukarela Di Hospital-hospital* dated 13 September 1994

3.9.4 Registered Non Governmental Organisation

The involvement of registered NGOs in various hospital outreach programme is strongly encouraged. However, involvement should be solely voluntary and with no vested interest.

3.10Public Relations

3.10.1 General

It shall be the policy of the hospital to have public relation officers with the following functions:

- To monitor and improve on the hospital's relations with those members of the public who, as patients, visitors or others, have contact with the hospital;
    - To serve clients through attending to inquiries and complaints, verbal or written complaints; provide advice and feedback to clients.
    - Manage and monitor all client services.
    - To propose recommendations for service improvement from client satisfaction survey conducted.

  - To publicize services and improvements in services provided to the clients.
- To maintain internal public relations so as to improve on staff information and communication and project a corporate identify;
- To coordinate the hospital's relations with the public through the news media.

3.10.2 Complaints and Feedbacks

i. The hospital management shall have in place a system whereby client grievances or complaints will be adequately addressed.

ii. The General Administration Unit shall be responsible for monitoring of comments or complaints. Complaints and comments shall be notified to the Hospital Director and the relevant department/unit as soon as possible, for further actions.

iii. Common source of complaints are:

- Verbal Complaints consist of complaints received in person, through 3rd party, and via telephone communication.

- Written Complaints are complaints received through letters, faxes, e-mails, feedback forms from suggestion box and others. (*Biro Pengaduan Awam*)

- Mass Media are complaints received through newspaper, radio and television.

iv. These complaints can be categorised into clinical and non-clinical including medico-legal issues and shall be managed according to urgency irrespective of the source of complaint.

v. All complaints received shall be registered, documented, investigated and appropriate action taken. Acknowledgement letter shall be issued within 24 hours and reply within 3 working days of receiving the complaint. Where possible, efforts shall be taken to contact the complainant.

vi. Investigation report shall be submitted to the relevant authority within 2 weeks of receiving the complaint. Independent Inquiry report for medico-legal cases should be submitted to the Medical Practice Division within 2 weeks of the meeting.

vii. The subsequent management of complaints shall be carried out in accordance with Guidelines on Management of Complaints and Medico Legal Cases, Medical Practice Division Ministry of Health Malaysia, March 2007.

3.10.3 Suggestion Box

Suggestion boxes shall be placed at strategic locations to get feedback and comments from the public with ample forms and pens made available to facilitate the feedback. The suggestion box shall be inspected daily.

3.10.4 Release of Information

- For ethical and legal reasons, all staff of the hospital shall respect and observe the confidentially of information, acquired either directly or indirectly, relating to any patients, his or her medical condition, diagnosis and treatment.

- Only the Hospital Director or his representative is authorized to give statements to the press with approval from higher authority.

- As the release of information on patients may have serious implications, any member of the staff who does not comply with this policy shall be subject to disciplinary action.

- Refer to: *(i) SPKPK Bil.13/2004 Mengenai Peraturan Membuat Kenyataan Kepada Media Massa Bercetakdan Elektronik serta Orang Ramai* dated 5 November 2004

3.10.5 Photography/Filming/Interviews

- No photographing, filming, etc. shall be carried out within the premises of the hospital without the prior permission of the Hospital Director.

- Use of hospital personnel, ambulances or equipment shall not be allowed for filming.

- Permission for the privilege of photographing a patient in the hospital may be given if
  - In the opinion of the doctor in charge of the case, the patient's condition will not be jeopardized.
  - The patient (or in the case of a minor, the parent or guardian) is willing to be photographed.

- Interviews of patient shall not be allowed if he (or patient's parent or guardian) objects or in the opinion of the attending doctor, the patient's condition does not permit it.

3.10.6 Public Forums And Exhibition

i. Hospital shall organize talks or exhibition to provide health education to the public.

ii. Health promotional activities shall also be organized to create public awareness and encourage public participation.

4.0 CLINICAL GOVERNANCE

a. Protocols and procedures shall be developed or adopted.
b. All protocols & procedures developed or received should be communicated and made accessible to all relevant staff.
c. All Heads of Department and managers shall ensure compliance to standard protocols & procedures.
d. All Heads of Department concern should agree and align over protocols & procedures that involve 2 or more departments.

4.1 Patient and Family Rights

To create awareness and education on patient's right for all hospital staff. Patients will be given an information leaflet on his/her rights upon admission.

4.1.1 Right To Health Care And Humane Treatment

i. Every patient shall be treated with care, consideration, respect and dignity without discrimination of any kind.

ii. All drugs dispensed shall be of acceptable standards in terms of quality, efficacy and safety as determined by the Drug Control Authority of Malaysia.

iii. Patients shall be interviewed and examined in surroundings designed to ensure reasonable privacy and shall have the right to be chaperoned during any physical examination or treatment, except in cases of emergency where such conditions may not be possible.

iv. A child admitted to hospital shall, whenever possible, have the right to the company of a parent or guardian.

4.1.2 Right To Choice Of Care

i. A patient has the right to a second opinion at any time.

ii. A patient shall have the right to know the investigations conducted, the results of these investigations and a copy of the medical reports and have them explained. The patient shall also have the right to authorise in writing another health professional to obtain a copy of the same and inform him or her of what they contain.

iii. A patient shall, whenever possible, have the right to be treated at a hospital of choice and to be referred to a consultant of choice.

iv. A patient who has received adequate information about his or her condition during consultation shall have the right to accept or to refuse treatment.

v. If a patient's health professional refuses to allow another health professional to be called in, or breaches any other provisions of this charter, the patient shall have the right to discharge that health professional and seek the services of another.

4.1.3 Right To Acceptable Safety

Before any treatment or investigation, a patient shall have the right to a clear, concise explanation in lay terms of the proposed procedure and of any available alternative procedure. Where applicable the explanation shall incorporate information on significant risks, side-effects, or after-effects, problems relating to recuperation, likelihood of success, risks thereof, and whether the proposed procedure is to be administered by or in the presence of students. A patient may refuse any treatment or investigation.

4.1.4 Right To Adequate Information

i. A Patient shall have the right to know the identity and professional status of the individuals providing service to the patient and to know which health professional is primarily responsible for the patient's care.

ii. A patient shall have the right to information regarding all aspects of medication, including :

- The right to adequate and understandable information on prescribed and purchased medicines.
- The right to the most effective and safe medicines. Safety must be ensured by the manufacturers and by legislative control.
- The right to convenient access to medicines.

iii. All medicines shall be labeled, and shall include the international non-proprietary name (INN) of the medicine, the dosage and how often the medicine has to be taken. In addition, the patient shall be informed about medication, including the following :-

- The purpose of the medicine
- The possible side effects
- The avoidance of any food, alcoholic beverages or other drugs
- The duration necessary for any medication prescribed
- The measures to be taken if a dose is forgotten or if an overdose is taken.

iv. A patient shall have the right to an itemized account after any treatment or consultation and to have this explained.

v. If a patient is in hospital or any health care facility, the patient shall, unless unconscious be consulted about any decision to discharge or transfer the patient to another facility.

vi. Where it is appropriate to a patient's condition or treatment, the patient shall be given advice about self-care, drugs administration, special precautions, which may be necessary or desirable, and the existence of special associations, facilities, aids or appliances which may be of assistance.

vii. A patient shall have the right to have the details of the patient's condition, treatment, prognosis and all communication and other records relating to the patient's care to be treated as confidential, unless :

- authorised in writing by the patient
- it is undesirable on medical grounds to seek a patient's consent but it is in the patient's own interest that confidentiality should be broken.
- the information is required by due legal process.

4.1.5 Consent

i. Consent shall be obtained from the patient or next-of-kin prior to carrying out any clinical procedures. Consent shall be obtained from the patient if he / she is 18 years old or more, physically and mentally competence.

ii. In live-saving situation where all efforts to trace relatives and next-of-kin have failed, two clinical specialists, one of whom is from the related discipline can give consent for the operative/invasive procedure to be carried out. The consent and efforts made to trace the relatives/ next-of-kin shall be documented in the case notes.

iii. In live-saving situation, implied consent is assumed for immediate life-saving non-operative procedures such as intubation, chest tube insertion.

iv. All consent must be taken by a medical officer or specialist performing the procedure using the consent/appropriate form. There shall be a witness to the consent. The communication includes but not restricted to:
- patient's condition
- proposed treatment/ procedure
- potential benefits and risks
- likelihood of success/ failure
- possible alternatives
- possible problems related to recovery
- possible results of non treatment

v. For patients below the age of 18 or patient of unsound mind consent shall be obtained from the legal guardian.

vi. Consent shall also be obtained from patient or next-of-kin when body parts or organ are taken for academic or research use.

vii. For a mentally disordered patient who is required to undergo surgery, electroconvulsive therapy or clinical trials, consent for any of them may be given by:-

(1) The patient himself if he is capable of giving consent as assessed by a psychiatrist;
(2) His guardian in the case of a minor or a relative in the case of an adult, if the patient is incapable of giving consent;
(3) Two psychiatrists, one of whom shall be the attending psychiatrist, if there is no guardian or relative of the patient or traceable and the patient himself is incapable of giving consent. In the event where there is only one psychiatrist, the Hospital Director shall give the consent.

viii. For a patient below the age of 18 who required a medical treatment, consent shall be obtained as below:-

(1) If, in the opinion of a medical officer, the patient requires surgery or psychiatric treatment due to serious illness, injury or condition, the consent shall be given by the parents/ guardian of the child/ any persons having authority to consent for the treatment

(2) If, the medical officer has certified in writing that there is an immediate risk to the health of a child and medical/ surgical/ psychiatry treatment is necessary, a Protector may authorize without obtaining the consent from the parents/ guardian of the child/ any persons having the authority, but only under any of the following circumstances:-

- that the parents/ guardian of the child/ any persons having the authority to consent to the treatment has unreasonably refuse to give, or abstained from giving consent to such treatment;

- that the parents/ guardian of the child/ any persons having the authority to consent is not available or cannot be found within a reasonable time;

- the Protector believes on reasonable grounds that the parents/ guardian/the authorized person has ill-treated, neglected, abandoned or exposed, or sexually abused the child. (According to Child Act 2001, Protector is defined as the Director General, the Deputy Director General, a Divisional Director of Social Welfare, Department or Social Welfare, the State Director of Social Welfare of each of the State, any Social Welfare officer appointed)

(3) In the event where there is difficulty contacting the child protector and the life of the child is at stake, 2 clinicians can give the consent for treatment.

ix. A patient's consent shall be required for the inclusion of a patient in any research. The patient shall be adequately informed of the aims, methods, anticipated benefits and potential hazards of the study and the discomfort it may entail. The patient shall be informed that he or she is at liberty to abstain from participation in the study and that he or she is free to withdraw his or her consent to participation at any time. To ensure that the informed consent is not obtained under duress or from a patient in a dependent relationship to the health professional, the informed consent shall be obtained by a health professional who is not engaged in the investigation and who is completely independent of the official relationship between the patient and the health professional. In the case of a child the informed consent shall be obtained from the parent or guardian.

4.1.6 Right To Redress Of Grievances

i. A patient shall have access to appropriate grievance redress mechanisms.

ii. A patient shall have the right to seek legal advice as regards any alleged malpractice by the hospital, the hospital staff or by a doctor or other health professional.

iii. A patient shall have the right to recover damages for injury or illness incurred or aggravated as a result of the failure of the health professional to exercise the duty and standard of care required of him or her while treating the patient.

4.1.7 Right To Participation And Representation

A patient shall have the right to participate in decision-making affecting the patient's health :

- with the health professionals and personnel involved in direct healthcare:
- through consumer and community representation in planning and evaluating the system of health services, the types and qualities of service and the conditions under which health services are or were delivered.

4.1.7 Right To Health Education

Every individual shall have the right to seek and obtain advice with regards to promotive, preventive and curative medicine, and rehabilitation to maintain or regain good health and a healthy lifestyle.

4.1.8 Right To A Healthy Environment

Every individual shall have the right to an environment that is conducive to good health. This includes and extends to a healthy and safe work environment, a healthy and safe home environment, and a healthy and safe environment at the place where he gets his medical care and treatment.

4.2 Patient Safety

a. Awareness and Education

Create awareness & education on patient safety for all hospital staff.

b. Best Practices In Healthcare

Apply best practices in healthcare in all clinical services to ensure patient safety:

i. Hand hygiene: Clean care is safer care.
ii. MOH Safe Surgery Checklist: Safe surgery saves lives
iii. MOH Patient Safety Goals
iv. GPSC: "Tracking Anti-microbial resistance"
v. Taxonomy for patient safety: Incident reporting &Incident classification for patient safety
vi. Transfusion safety: MOH "Hemovigilance" program to monitor the adverse transfusion events
vii. Clinical audit to identify safety issues: Peri-operative morbidity & mortality review (POMR), Perinatal mortality review, Maternal mortality review, Mortality reviews in respective clinical disciplines, Intensive Care audit etc.

c. Evidence-Based Patient Safety Solutions

Identify & implement evidence-based patient safety solutions by using care bundles or Standard Operating Protocol (SOP):

i. Proper managing concentrated injectable medicines
ii. Assuring medication accuracy at transitions in care
iii. Communication during patient care handovers
iv. SOP to reduce the risk of patient harm resulting from falls
v. Ventilator associated pneumonia care bundle
vi. Catheter related blood stream infection care bundle

d. Risk Management

i. The hospital shall actively identify potential risk for patients and the organization and implement preventive measures.

ii. Incident reporting should be actively done by staff.

iii. All incidents with risk of recurring and moderate to severe impact should have root cause analysis done and action plan implemented and evaluated. The management of incident should comply with the existing guideline.

4.3 One Stop Counter Service

i. The one-stop service counter shall serve the following functions:
   - Registration
   - Appointment

- Providing information
- Providing assistance
- Receiving suggestion or complaint etc.

ii. The counter shall be manned by competent persons with good public relations skill.

iii. Senior staff shall supervise the effective delivery of related counters.

iv. All counters shall be operational according to determined schedule.

v. Priority shall be given at the specialist counter to the following clients:

- Children age one year and below
- Senior citizen (75 and above)
- Blood donors (according to existing guidelines)
- Disabled persons *(Orang Kelainan Upaya)*
- Persons in custody *(Orang Kena Tahan)*

vi. Refer to*: (i) SPKPK Bil.1/2005 Garis Panduan Pengurusan Masa Menunggu di Klinik-klinik Pakardan di Jabatan Kecemasan di Hospital-hospital KKM* dated 1 June 2005*;* in line with *SPKPK Bil 6/2004 Langkah-langkah untuk Mengurangkan Masa Menunggu di Kemudahan-kemudahan Kesihatan* dated 20 July 2004

4.4 Appointment and Scheduling

i. Services shall be given on an appointment basis except for Emergency and Trauma Department.

ii. Appointment may be made by the referring doctors through phone, fax or coming personally to the clinic.

iii. Reminders on appointment to specialist clinic shall be done through SMS for patient accessible to the service.

iv. Request for early appointment will only be made on the approval of the respective specialist.

v. All clients shall be informed of the relevant document/item to facilitate registration process e.g. referral letter, appointment card, guarantee lette*r (e-GL)* etc.

vi. Defaulters to specialist clinic will be given reappointment date on presentation but medication will be supplied based on previous prescription for a maximum of one month and advised to visit polyclinic if there is any change of medical condition prior to the reappointment date.

vii. The reappointment date for defaulter should be within one month.

viii. Those who default specialist clinic appointment 3 times consecutively will be deemed discharging themselves from the specialist clinic.

4.5 Registration& Admission

i. Patients shall be given only one medical record number (MRN) for personal identification. Patients are registered based on their identification numbers, passports (for foreigners), armed forces/ police identification cards. The registration numbers shall be used in all forms/ documents pertaining to patient care.

ii. Children below the age of 12 shall be registered using their MyKid or under 7 card.

iii. The staff at the registration counter shall be responsible for ensuring the completeness of the information on the registration format and also to enter into the SMRP system.

iv. All clients requiring registration must present relevant documents at the designated registration counters.

4.5.1 General Patients

Patients shall be admitted through the admission counter to all wards during office hours. Other times it shall be carried out by the Emergency and Trauma Department.

4.5.1.1.Registration Of Admission

i.Registration of all admission shall be made at the admission office:

- Counter 35 of Block A during office hours
- the registration counter at Emergency Department after office hours.

ii.Emergency cases may be transferred directly from the Emergency & Trauma Department to the ward e.g. ICU or OT, and the admission formalities attended to subsequently.

iii.A bed head ticket and other relevant documents should be created for each new patient at the admission office.

4.5.1.2 Deposit And Guarantee Letter

Patients or their relatives for First and Second Class ward and foreigners shall pay a deposit and shall settle their bills upon discharge from the hospital. For government servants, e-GL can be obtained at the following counters:

i. Labour Room
ii. Admission Counter

4.5.1.3 Patients shall be transported on mobile beds, transport trolleys (incubator / cot bed / bassinet) or wheelchairs escorted by medical staff.

4.5.1.4 The ward / department personnel shall be responsible for transporting / accompanying patients within the department as well as to other departments.

4.5.1.5 Admission of patient to specific ward shall be withhold if/when the ward is temporarily gazetted as infectious disease ward during outbreak of infectious disease.

4.5.1.6 Admission of pregnant mother with non-O&G problem:

i. All pregnant mothers with gestational week 22 weeks and below shall be admitted to the ward of the primary team.

ii. Pregnant mother with gestational week more than 22 weeks presented with non-O&G problem shall preferably be admitted to O&G wards but under the care of the primary team. If in the opinion of the primary care team the mother is deemed better managed in the primary care team ward, admission will still be to the respective wards.

4.5.2 Admission Through Emergency and Trauma (E&T) Department

i.All the cases should be assessed and stabilized at the E&T Department. If the patient is unstable, appropriate resuscitation should be initiated immediately and the primary team should also be informed without delay.

ii.The Primary team shall come to A&E Department as soon as possible to help with subsequent assessment and resuscitation. Once the patient's condition is suitable for transfer, the appropriate ward should be informed of the admission.

iii.All paediatric cases presented after 12 midnight should be admitted unless the Paediatrician or Paediatric MO allows discharge.

iv.All patients with recurrent presentation for similar complaint/condition to E&T within 5 days should be admitted unless reviewed and discharged by Emergency Physician or respective discipline clinician.

v.All pregnant mother and postnatal mother can ONLY be discharged by Medical Officer regardless of presenting symptoms.

vi.All pregnant mothers who presented twice to Emergency & Trauma Department for any similar complaints must be admitted for further management.

4.5.3 Admission of referred Cases

i. Stable patients from the referring hospital shall be admitted directly to the relevant ward after consultation with the specialist on-call and handover done at the ward by the escorting team. All referrals for admission shall be

in accordance with existing guidelines as stated in the *Pekeliling Ketua Pengarah Kesihatan* 2/2009; *Rujukan Dan Perpindahan Pesakit Diantara Hospital-Hospital Kementerian Kesihatan*

ii. All unstable patients shall be stabilized in the Emergency Department before admission to the ward. In the event the primary team could not review the patient in Emergency & Trauma Department within one hour of arrival, escorting team will be allowed to hand over the case to the attending officer. Direct admission to the Intensive Care for very ill patient shall be arranged with prior consultation and agreement by the Specialist in charge.

4.5.4 Mothers In Labour

All expecting mothers presenting for delivery or reasons related to pregnancy with 22 weeks of gestation and above are admitted directly to Labour Room and the necessary admission formalities attended to subsequently.

4.5.5 Admission Of In-Born Babies

The paediatric team shall be notified early of impending high risk delivery so that preparation could be made in advance. In-born babies requiring Neonatal Care shall be directly admitted to SCN/NICU through labour room, postnatal ward or operating theater.

Refer to *(i) SPKPK 2/2009 Garis Panduan Rujukan dan Perpindahan Pesakit di Antara Hospital-hospital KKM* dated May 2009,*(ii) SPKPK Bil.6/2001 Penyelarasan Panduan Kemasukan Pesakit ke Hospital* dated 2 April 2001.

4.5.6 Admission Of "Walk-In Patient" Into The Ward

Selected groups of patients as specified by specialists e.g. oncology patients are given privileges to have liberal access to the wards to obtain help. These patients shall be assessed first by the ward doctor on-duty and be admitted directly into the ward if required. The admission formalities are attended to subsequently.

4.5.7 Admission to First Class Wards

i. Patients shall be admitted to First Class wards when the necessary financial circulars have been complied with on a 'first come first serve' basis.

ii. Decision to admit the patient to First Class shall be determined / verify by a specialist according to clinical condition.

iii. When patient's clinical condition becomes 'unstable' and requires Intensive care, patient shall be transferred to HDW/ICU/CCU and bed shall be vacated. Patient in the waiting list can be admitted to occupy the bed.

iv. When there is no available bed in the First Class patient shall be admitted to Second or Third Class ward and put on a wait list for First Class. Transfer shall be made when bed is available.

v. Admission of Royalties / VVIPs / VIPs shall be based on the respective state / national protocol.

4.5.8 Dangerously Ill List Patient (DIL)

The Medical Officer / Specialist in charge of all patients deemed seriously ill shall be responsible for communicating this information to the relatives / next-of-kin in a tactful manner that is clearly understood by them. Documentation of this shall be recorded in the patient's case notes.

4.5.9 Admission of Unknown Patients [comatose, psychiatric, amnesic, etc]

i. All available information pertaining to the unknown patient admitted shall be documented into the admission book as 'unknown patient' and a registration number / medical registration number (MRN) given.

v. The police shall be notified immediately and re-notified if the patient remains unidentified after 24 hours.

vi. If the patient is still unidentified after 48 hour information may be disseminated through the mass media via the Medical Social Department and Public Relations Officer/ hospital management.

4.6 Discharge

4.6.1 Routine or Planned Discharge

i. The ward MO or specialist shall decide when to discharge a patient from hospital. The HO is not authorized to discharge a patient without prior consultation with his senior doctor.

ii. All discharges shall be planned as early as possible. The doctor shall notify the family of the impending discharge not less than 24 hours in advance for planned discharge. The discharges for rural patients should be done before noon so that the patients could reach home on the same day.

iii. A diagnosis shall be made before a patient is discharged. Doctors have to complete the discharge summary within 72 hours of discharge. All the patients will be given a

discharge note which should include the diagnosis, relevant clinical information and follow-up plan.

iv. Identification wrist bands shall be removed at discharge except for newborn and paediatrics cases.

v. Ward nurse shall ensure only parents/guardians are allowed to take discharged children home. Only parents are allowed to take home discharged babies/newborns.

vi. All patient deemed fit for discharge shall be provided with a prescription and relevant information about their medication prior to discharge.

vii. All discharged patient must settle their bills in accordance with "the Fees [Medical] Order 1982 and the Revised Circulars" 'No. [44 dlm. KKM 203/20 Jld. 6] *Panduan Perlaksanaan Perintah Fi [Perubatan] Pindaan 2003 – Caj Baru Bagi Pesakit Orang Asing'* and official receipt issued.

viii. Citizens (Patient) who are unable to settle their bill due to financial reason will be referred to the exemption officer on duty.

ix. All the bed head tickets shall be dispatched to Medical Records Office within 3 working days. The ward sister shall be responsible for the security and movements of all the bed head tickets

4.6.2 Discharge And Transfer Of Patient To Another Hospital

Only the specialist is authorized to discharge and transfer patients to another hospital. The ward doctor shall inform the receiving doctor of the other hospital about the transfer. A referral letter shall be enclosed with the transfer.

4.6.3 Discharged At Own Risk (Adult patient)

i. All patients requesting to be discharged against medical advice can do so after obtaining adequate explanation and clarification and from the medical officer in charge unless not in compliance to the Prevention and Control of Infectious Diseases Act 1988 (Act 342) and mental Health Act (Act 615).

ii. The AOR discharge form has to be completed by the medical officer in charge and signed by the patient / relatives / guardian and witness.

iii. On discharge (including AOR discharge), patients shall be provided with relevant documents related to their admission, follow up and further management e.g.
discharge notes, medical certificate, appointment card etc.

iv. Refer to: SPKPK Bil.11/2013, *Prosedur Mengenai Pesakit Yang Ingin Discaj dari Hospital Atas Risiko Sendiri* dated 12 Dec 2013.

4.6.4 Discharged At Own Risk (Paediatric Patient)

The family of a child who insists on discharge against medical advice may do so in writing by using an appropriate form provided it is done in the child's best interest. However, if the discharge is deemed insensible and could potentially endanger the child's life, the ward doctors should protect the child in question and should inform the Child Protector (designated social welfare officer) and a court order may be obtained if necessary (Child Act, 2001). All the other procedures should comply with the *Surat Pekeliling Ketua Pengarah Kesihatan Bil. 11/2013, Prosedur Mengenai Pesakit Yang Ingin Discaj dari Hospital Atas Risiko Sendiri.*

4.6.5 Absconded patient

i. Patients shall not be allowed to leave the ward without permission. Those leaving the ward without permission shall be declared as 'absconded'.

ii. If a patient is found to be missing from the ward / bed, all efforts shall be made to locate him / her within the vicinity of the Hospital. The ward staff shall notify the next- of-kin immediately.

iii. A police report shall be made within 24 hours.

4.7 Referrals

4.7.1 Inter-Disciplinary Referral / Transfer Of Patients In The Hospital

i. The primary care team is responsible for the care of patient. However, multidisciplinary approach should be used in the management of patients with multiple medical problems. Interdepartmental referral and transfer of patient care should be made appropriately. The ward doctor/specialist may consult or refer a patient to another discipline by phone or using referral letter.

ii. The specialist of the referred discipline may just give advice and joint manage the patient in the existing ward. Alternatively, he may prefer the patient to be transferred to his own ward for further management. The specialist of the primary team should be informed before the transfer.

iii. The referring doctor and nurse shall inform the family and their colleagues of the receiving ward about the transfer. The doctor and nurse shall make all the necessary documentation in the BHT to ensure continuity of care

iv. The ward attendant and/or the nursing staff and/or doctor shall be responsible for moving patients within the department as well as to other department. All ill patients must be escorted by a doctor and a nurse/Assistant Medical Officer. Patients should be monitored as required during the transfer between wards and proper handing over must be done at the receiving ward.

v. Patients shall be transported on mobile beds (cots, bassinets, and cribs), wheelchairs or trolleys. Ambulant patients may be escorted on foot.

vi. All inter-ward transfer of patients shall be recorded and updated in the ward census.

vii. Patient requiring sub-specialty care not available in the hospital should be referred promptly by the primary care team. However, the primary care team is still fully responsible for the care of patient while awaiting transfer. External referral of patient should be made by the relevant disciplines.

viii. Referral of pregnant mother admitted in non-O&G wards:

a. All pregnant mothers admitted to non-O&G wards must be referred to:

- On-call O&G M.O or specialist
- O&G nursing team at Maternity 2 for appropriate colour coding and timely High Risk E-notification within 24 hrs.
- Refer to Ministry of Health circular dated 23 January 2014 *titled "Edaran Cabutan Minit Mesyuarat Semakan Laporan Kematian Ibu Bil. 01/2014" ref no. "Bil (54) KKM/62/BPKK(M)/MM1-e"*

b. Timing and location of assessment would depend on the condition of the patient

c. Maternal obstetric and fetal monitoring are to be performed by the nursing team of the respective wards.

d. If the patient is for discharge, inform O&G team to ensure proper discharge plan are in-place e.g. E –notification on discharge of High Risk cases, appropriate clinic follow-up or registration (for unbooked cases), etc.

e. If the patient is in labour or has concurrent acute obstetric problems, she should preferably be managed in O&G wards after discussion with O&G specialist on-call.

f. When patients in non-O&G wards develop obstetric-related problems e.g. signs and symptoms of labour, antepartum haemorrhage, reduce fetal movement, etc, the nursing team of that discipline are allowed to refer those cases **directly to O&G MO on-call** without going through their own doctors, especially if any delay is anticipated. This is to ensure that no delay in review and institution of appropriate care. The M.O of the concerned discipline should still be informed to ensure continuity of care for the patient's medical problems in O&G wards.

g. In the event that O&G M.O review is delayed, the O&G specialist shall be informed and the case is to be sent directly to Labour Ward for assessment after informing the labour ward nursing team.

4.7.2 Inter Facility Transfer

i. Patient transfer is a doctor-to-doctor referral. House Officers are not allowed to refer or accept cases.

ii. The decision to transfer a patient for higher level care shall be made upon consultation with the specialist concerned.

iii. The referring medical officer/ specialist must contact the relevant medical officer/specialist at the receiving hospital to discuss on the necessity of transferring the patient and medical doctor/ specialist must agree to accept the patient prior to the transfer taking place.

iv. If the referral is indicated but is not accepted by the doctor/ specialist (of the receiving hospital), the referring doctor shall inform his/ her superior (specialist/Hospital Director).

v. The patient's next-of-kin shall be informed about the process of transfer. In emergency situations when a patient is unable to agree to transfer and the next-of- kin are not contactable, the police shall be informed to help in contacting them. The responsibility for transfer rests with the doctor/ specialist in charge of the patient and the consent of the relatives is not always required.

vi. All patients shall be stabilized and deemed stable before transfer.

vii. All transfer requiring the Medevac service shall obtain the prior approval of the Hospital Director and the approval of the relevant personnel at Sarawak Medical Headquarter before proceed with the arrangement.

viii. The staff accompanying referred cases shall be decided by the medical officer or specialist in charge, after consultation with the receiving hospital. In the event of critical shortage of Medical Officer, House Officer may be allowed to escort patients provided that all relevant information and management during transfer is properly communicated. However, House Officers are not allowed to escort critical ill patients.

ix. All critical patients shall be accompanied by paramedics trained in resuscitation and headed by a medical officer. Accompanying staff for other cases shall be decided by the specialist/ medical officer in charge based upon the clinical condition of the patients. Monitoring of patients shall be done based on the clinical condition of the patient and recorded accordingly.

x. Documents pertaining to patient's condition shall be made available to facilitate the transfer. This includes a referral letter with detail history of the patient and reason for

referral. All related radiological images and other investigation results (e.g. blood results) should be included.

xi. A patient may be referred to the Emergency Department or directly to the appropriate ward/ care unit. The accompanying team shall have clear instructions as to their exact destination (e.g. which ward to go) prior to arrival at the receiving hospital to avoid delay.

xii. The accompanying team shall not leave the patient until the receiving team has formally taken over care of the patient.

xiii. If patient's clinical condition deteriorate during the transfer and resuscitation is required, the ambulance may en route to the nearest health facility or directed immediately to the Emergency Department of the receiving hospital.

xiv. If death occurs during transfer, it shall be certified by a medical officer and the body shall be brought back to the referring hospital.

xv. Refer to (i) *SPKPK Bil. 2/2009 Garis Panduan Rujukan dan Perpindahan Pesakit di antara Hospital-hospital KKM* dated May 2009.

4.8 Death

4.8.1 Death at Hospital

i. The attending doctor in the ward or the emergency and trauma department shall carry out confirmation of death.The attending doctor, on confirming death of patient, shall register the death using the form *"Daftar Kematian / Permit Mengkubur JPN.LM02 (Pin.1/11)".* House Officers shall not be allowed to sign the above document.

ii. The family shall be informed by medical staff of patient's death in the ward. If they are not available, they may be notified by phone or radio message service, if necessary.

iii. The deceased body shall be transported to the mortuary at the end of an hour and be released to the family immediately if so requested provided that no postmortem examination is required and the case is not infectious. Alternatively, the deceased body shall be transported and kept in the mortuary for subsequent release to the family.

iv. The mortuary attendants shall be responsible for transporting the deceased to the mortuary with the designated trolley.

v. Body of the deceased must be tagged with a body tag bearing the identity of the deceased, a white tag for cases not requiring autopsy and a red tag for cases requiring autopsy.

vi. All deaths in the hospital shall be registered at the mortuary. Bodies shall be released to the next- of- kin or authorised person through the mortuary. All information on body release shall be documented.

vii. In the case of referred patient, the hospital shall be responsible for the transfer back of the dead body to the referring government hospital which is accessible by road.

viii. Unclaimed bodies (non-medicolegal cases) shall be notified to the police and notices placed in newspaper after 3 days (Muslim) and 14 days (non-Muslim). The body shall be handed over to the respective religious body for burial or cremation if no claim is made after the said days following notification.

ix. For unclaimed bodies of non-citizen, the respective embassies shall be notified of the death.

x. Management and handling of infectious dead bodies shall be in accordance to the standard procedures to prevent cross infection. The Health Inspector in the District Health Office shall be notified.

xi. Existing guidelines such as *Polisi dan Prosedur Kawalan Jangkitan, Kementerian Kesihatan Malaysia* and the Disinfection and Sterilization Policy and Practice 2002 shall be complied with.

xii. Unclaimed bodies shall be handed to the local medical faculties for the purpose ofeducation and research if they fulfilled the criterias and all the procedures are followed.

xiii. Refer to *(i) SPKPK 5/2008 Garispanduan Penyerahan Mayat-mayat Yang Tidak Dituntut Di Hospital KKM kepada Fakulti Perubatan Universiti Tempatan bagi Maksud Pendidikan dan Penyelidikan Perubatan* dated 5 May 2008*)ii) SPKPK Bil.1/1998 Garispanduan Penggunaan Format PNM1/97 Bagi Melapor Kematian Perinatal.*

4.8.2Brought in dead (B.I.D)

i. All B.I.D cases brought by police shall go directly to the mortuary after informing Emergency and Trauma Department.

ii. B.I.D cases brought by families/ public shall be seen and registered in Emergency Department and a police report shall be made before transferring the body to Mortuary in the event that the Medical Officer in charge of mortuary is not available.

iii. The police shall decide the need for forensic post-mortem examination according to the cases.

iv. For cases which require Crime Scene Investigation (CSI) as requested by the police, the Assistant Medical Officer on duty shall inform the Forensic Medicine specialist/ consultant immediately.

v. The body can be released after all the relevant procedures and documentation is done in accordance with the stipulated guidelines.

vi. Refer to SPKPK Bil.10/2012 Standard Operating Procedures Of Forensic Medicine Services

4.8.3 Post Mortem

i. When the cause of death could not be determined, a clinical post mortem maybe requested by the specialist in charge. Consent from the next-of-kin must be obtained before a post mortem is performed.

ii. For medicolegal / police cases, the police shall be informed of the death. The police may issue a post mortem request.

iii. Post mortem shall be performed by the Forensic Pathologist or a competent Medical Officer according to the necessity of cases.

iv. Refer to: *(i)* SPKPK Bil.10/2012 Standard Operating Procedures of Forensic Medicine Services.

4.9 Patient Related Policies In The Ward

4.9.1 General Ward Policies & Procedures

i. Wards ready to receive new patients at all times
The wards shall be ready to receive new patients at all times. Whenever the ward has been fully occupied and no additional beds could be added, the staff nurse should notify the nursing sister of the ward, the nursing matron and /or he hospital director.

Any vacant beds shall be made ready on standby within 2 hours after discharge of previous patients. The ward staff shall make all the necessary preparations after receiving phone calls from the Emergency and Trauma Department regarding the admission of new patients.

ii. Placement of the patients in the ward
The placement of the patients in the ward shall base on their clinical condition and/or the working diagnosis of the patients. After initial assessment, ill patients should be placed near the nursing station or high dependency cubicle to permit closer observation and monitoring. The patient requiring isolation should be nursed in the single room whenever possible provided his/her condition is stable and safe without close observation and monitoring. All respiratory patients with potential of infecting others should be cohorted as best possible.

iii. Attending, clerking and reviewing of patients

The ward staff need to inform the doctor on duty of all new cases admitted as soon as possible**.** If that particular doctor on duty is busy, the staff should then inform another doctor or specialist on duty.

All new patients shall be attended to and clerked by the doctor on duty within 1 hour of admission. They shall then be reviewed by a senior medical officer and/ or the specialist based on the severity and urgency of their clinical conditions. Acutely ill patient shall be reviewed immediately (within ½ hour) whereas stable patient shall be reviewed within 4 hours. All female patients examined by a male medical staff shall be chaperoned by a female staff

iv. Frequency of patient review

The Specialist/MO on duty shall review all the patients at least once a day for stable cases and more frequently for unstable cases. For TB patient admitted for DOTS, the specialist shall review at least once per week or more frequent depending on the condition of the patients.

All peripheral patients referred to any discipline shall be reviewed daily or as required as deem necessary by the respective discipline unless the patient is discharged from the discipline.

v. Patient bed head ticket

The doctors and all allied health staff shall keep up-to-date records in the patient's bed head ticket at all times. All BHT shall be documented clearly with legible handwriting. Only well accepted and standard abbreviations/symbols are allowed. All BHT entry shall be dated, timed, signed and followed by the staff's name (stamped or written in print)

vi. Patient meals

All patients shall be supplied with 4 meals a day. Dietary guidelines produced by the Ministry of Health shall be followed. Mother accompanying child shall also be provided with meals. Patients' meals shall be brought to the wards in specific food trolleys or plates and distributed to patients and mother or relative who is accompanying the child.

Patients are encouraged to use hospital plates, crockery and cutlery which should be returned to ward staff after use for dispatch to kitchen. The relatives are also allowed to bring food and drinks for the patients provided there is no contraindication & with approval from doctors.

vii. Notifiable diseases

All notifiable diseases shall be notified to the Divisional Health Office by phone by the medical officer in accordance to the Prevention And Control Of Infectious Diseases Act 1988. The operation room will enter the necessary information in the e-Notice system.

viii. Record and census of patients

The ward shall maintain a record of all the patients. A daily midnight census of patients shall be carried out.

ix. Patient under police custody
Any cases under police custody shall be guarded by the police unless permitted by the police otherwise.

i. Leave of absence for patient
No leave of absence shall be granted to patients unless permission granted by the ward MO in consultation with the specialist-in-charge.

x. Emergency trolley
An emergency trolley shall be made available at all times. The contents of the trolley shall be checked regularly and replenished accordingly

xi. Indenting of ward supplies
The sister in charge shall abide by a regular schedule for indenting surgical supplies, drugs and non-drug items from the Pharmacy and/ or the Surgical Store so that sufficient stock is available at all times.

xii. Ward equipment and assets
The ward sister shall maintain an updated inventory of all the ward equipment and assets. She shall ensure all equipment are regularly maintained in good functioning condition by the concession holders

xiii. Incident report
The ward shall maintain a record of any untoward incidents occurring in the ward as detailed in the Hospital Incident Reporting Flowchart.

xiv. Activities related to Quality Assurance Programs (QAP) and Key Performance Indicators (KPI)

All activities related to the relevant QAP and KPI of MOH shall be carried out, monitored, evaluated with remedial measures implemented accordingly.

4.9.2 Investigation Orders (Laboratory And Imaging)

i. Ordering of investigations
All investigations shall be ordered and endorsed by doctors. Some specialized investigations such as CT and MRI shall be ordered and endorsed by specialist and through TPC system. Informed consent shall be taken as required.

ii. Taking, labeling and dispatch of blood specimens
Blood specimens are to be taken by nurses or doctors. Blood specimens shall be labeled by ward staff clearly with legible handwriting. Blood specimens shall be dispatched to laboratory by porter service. However, urgent specimens shall be dispatched by ward attendant immediately.

All biological specimens with diagnostic potential should be sent for histopathology examination.

iii. Review of investigation results
The doctors on duty shall review all the investigation results before filing. They shall inform their senior medical officer or specialist of any significant or abnormal findings.

4.9.3 Prescription And Treatment Orders

i. Prescription of drugs
All medications prescribed to patients shall be in accordance to approved list of drugs of the Ministry of Health. All prescriptions should be written and signed by a doctor in the patient's drug chart in legible handwriting. Allergic status of the patient must be checked prior to prescription.

The medical officer and / or specialist shall check all prescriptions written by the house officer. The specialist shall countersign all the prescribed list A drugs.

ii. Serving of drugs
All drugs shall be served to the patients by trained staff according to the doctor's prescription in the patient's drug chart. All drug serving shall comply to the required procedures. All treatment orders shall also be recorded and signed legibly in the patient's BHT.

In the emergency or life threatening situation, the staff nurse is allowed to give a stat dose of drugs ordered verbally and to be indented and endorsed by the doctor(s) concerned at the earliest possible time.

4.9.4 Diagnostic And Therapeutic Procedures

i. Consent (Refer to 4.1.5)

ii. All procedures shall be carried out in the treatment room unless the patient could not be mobilized. Adequate privacy shall be ensured if procedures have to be carried out at the bedside.

iii. The family shall be allowed to witness any procedure if permission has been granted by the performing doctor.

iv. Supervision during procedures

The junior doctor shall perform the procedure under direct supervision until he is deemed to be competent by the senior medical officer / specialist.

v. Cases requiring surgery in the operating theatre shall abide by the policy of the operating theatre.

4.9.5 Procedure and Surgery

i. Each patient's procedure or surgery is planned and documented in the patient's case notes. Referral to the Anaesthetic Clinic is encouraged prior to elective surgery.

ii. All consent must be taken using the consent/appropriate form prior to procedure or surgery. Refer to that at 4.1.5 'Consent'.

iii. Efforts shall be made to ensure safe surgery such as :
- The right patient
- The right procedure
- The right site

iv. Upon arrival at the OT, the OT nurse shall verify with the relative / patient regarding the following based on a checklist:
- Patient's details
- Consent
- Type of operation
- Site of operation

v. The surgery performed is recorded using a prepared format and attached to the patient's case notes. Documentation should include the post operative diagnosis, a description of the surgical procedure, findings and any surgical specimen sent and the name of the surgeon and assistants. Patient post operative care plan is also documented.

vi. Refer to SPKPK 23/2009 *Pelaksanaan Inisiatif Keselamatan Pesakit*: Safe Surgery Saves Lives dated 12 November 2009. Anaesthetic Clinic Protocols, 2012

4.9.6 Ward Orientation And Communicating To The Patient And Family

i.Ward orientation and briefing

The patient/family shall be orientated on the facilities available in the ward e.g. toilet facilities, breast feeding room and waiting room for the family

The patient/ family shall be briefed on the relevant aspects of departmental and hospital policy, in particular certain rules and regulations of the hospital.

ii.Informing patient's condition and prognosis

Only the treating doctors shall inform the patient/family the condition & prognosis of the patient upon admission and whenever necessary

iii.Informing dangerously ill patient's condition

The family of dangerously ill patient shall be informed immediately. If they are not available, the message could be conveyed by telephone or radio message if he / she is not in the ward. If potential medico legal issues or the like is

anticipated, explanation should be made by the specialists in charge of the patient, or senior medical officer in the absence of specialists.

4.9.7 Patient Movement

i. General Patients.
Patients are transported on mobile beds, wheelchairs or trolleys. Ambulating patients are escorted on foot.

ii. Ward and department attendants
The ward or department attendants are responsible for moving patients within the department as well as to other departments. The following department attendants are responsible for moving patients within the department only:
- Diagnostic Imaging Department
- Physiotherapy Department
- Intensive Care Unit
- Operating Theatre Suite
- Special Care Nursery

iii. Critically ill patient.
- Transfer of critically ill patient to another center should be escorted by a doctor who is competent to handle any unexpected event. The hospital shall provide ambulance service for inter-facility transfer of patient.
- Inter-departmental transfer of critically ill patient should be escorted by a doctor or at least a competent staff nurse.

iv. Deceased.
The mortuary attendant transfers any patient who dies in the hospital on a cadaver trolley to the mortuary.

4.10 Infection Control

The hospital adopts the various recommendations set out in the second edition of Policies and Procedures on Infection Control, prepared by Quality Medical Care Section, Medical Development Division, Ministry of Health Malaysia. This will ensure more efficient and effective infection control, thereby minimising the healthcare-associated infection in the hospital

4.10.1 The Hospital Infection & Antibiotic Control Committee

i. Roles of Hospital Infection and Antibiotic Control Committee

1. The Hospital Infection and Antibiotic Control Committee (HIACC) is responsible for developing policies and procedures related to infection control and antibiotic usage in the hospital and its affiliated health facilities.

2. The HIACC is a source of expertise on matters relating to infection and antibiotic usage.
3. The HIACC advises the Hospital Director on technical matters related to Infection Control in the hospital.
4. The policies and procedures of the HIACC should be in line with the principles and general policies set out by the National Infection and Antibiotic Control Committee (NIACC)

4.10.2 The Hospital Infection Control Unit

i. Clinical Responsibility

1. Liaise closely with the hospital medical microbiologist and clinicians.
2. Supervise and advise on isolation technique policies and procedures generally and in specific clinical situations.
3. Provide clinical advice and support to doctors, nurses, assistant medical officers and other non-clinical personnel on infection control issues.
4. Analyze and provide feedback on microbiology reports to head of department.
5. Provide clinical advice and support to other health care professionals, ancillary staff and external agencies concerned with social issues arising from infection control matters.
6. Provide guidance and support to the ward link infection control nurses.

ii. Surveillance Responsibility

1. Coordinate surveillance activities on infections for the hospital.
2. Collect relevant information including point prevalence studies on healthcare-associated infections, clinical / antibiotic audits, hand hygiene compliance etc.

iii. Coordination/Organization of Infection Control Activities

1. Identify potential infection hazards and suggest appropriate remedial action to relevant personnel.
2. Work with the hospital Infection Control Team to identify, investigate and control outbreaks of infection.
3. Collaborate with the infection Control Team and clinicians about the routine monitoring of units, such as the intensive care and neonatal special care units, which are particularly vulnerableto infection.

iv. Administrative Responsibility

1. Participate in the development and implementation of the infection control policies.

2. Monitor compliance with infection control policies, including activities directly associated with audit.
3. Preparing timely reports.
4. Advise staff on the various aspects of infection control and occupational health safety.

v. Education

The Infection Control Nurse will**:**

1. Participate in informal and formal teaching programmes for all healthcare workers.
2. Keep abreast with recent advances by reading relevant literature and attending appropriate courses, meetings and exhibitions.
3. Advice staff with regards to the microbiologic hazards in occupational health safety.
4. Participate and coordinate infection control-related educational campaigns as instructed by the HIACC.

vi. Research and Quality Improvement Activities

1. Participate with the microbiologists and appropriate clinical staff on research projects that is related to hospital infection.
2. Evaluate implementation of infection control technique.
3. Audit infection control activities

4.10.3 Isolation Policies And Procedures

The purpose of isolating patients is to prevent the transmission of micro-organisms from infected or colonized patients to other patients, hospital visitors, and health care workers (who may subsequently transmit to other patients or become infected or colonized themselves).

i. Standard Precautions:

- Apply to all health care personnel and patients regardless of diagnosis of patient.
- Are designed to reduce the risk of transmission of micro-organisms fromboth recognized and unrecognized sources of infection in the hospital.
- Shall be implemented when contact with any of the following are anticipated:
    - Blood
    - All body fluids, secretions and excretions**,** with the exception of sweat regardless of whether or not they contain visible blood.
    - Non-intact skin (this includes rashes)

- Mucous membranes

- **Standard Precautions Requirements**
  - Hand hygiene:

    Must be practiced promptly aftertouching blood, body fluids, secretions or excretions whether or not gloves wereworn. In addition, hand hygiene must be practiced after gloves are removed andbetween patient contacts. Finally, hand hygiene must be practiced when tasks orprocedures on the same patient involve different body sites in order to prevent cross contaminationbetween body sites.

  - Gloves:
    Clean gloves must be worn when touching blood,body fluids, excretions, secretions and contaminated items and when performingvenipuncture.

  - Mask, eye protection & face shield:
    Must be worn duringprocedures or patient care activities that are expected to generate splashes or spraysof blood, body fluids, secretions and excretions. For example, suctioning, irrigating wounds, performing certain laboratory tests, etc.

  - Gown or Apron :
    Must be worn to protect skin and to preventsoiling of clothing during procedures or patient care activities that are expected togenerate splashes or sprays of blood, body fluid, secretions and excretions.

  - Patient care equipment: (*see chapter on Disinfectants &Sterilisation*)
    Must becleaned according to protocol with MOH-approved disinfectant before being used foranother patient.

  - Linen:
    Place contaminated linen directly into a laundry bag in the isolation room/area with minimal manipulation or agitation to avoid contamination of air, surfaces, and persons.

  - Waste management:
    - Clinical waste
      - Discarded sharps;
      - Laboratory and associated waste directly associated with specimen processing;
      - Human tissues, including material or solutions containing free-flowing blood; and
      - Animal tissue or carcasses used in research.

    - Related waste
      - Cytotoxic waste

- Pharmaceutical waste
- Chemical waste
- Radioactive waste.
- General waste includes other wastes that do not fall into the above categories

▪ Waste segregation:
- Domestic waste – Bin lined with black bag.
- Clinical waste (non sharp) – Bin lined with yellow bag.
- Clinical waste (sharps) – Sharps bin

o Management of spills

Small spills - Remove with absorbent material, wipe with Sodium hypochlorite 1:10.

Large spills - Cover spillage with absorbent material, pour Sodium hypochlorite1:10 and leave for 5-10 min. Wipe up with absorbent material and place in yellow bin.OR

Sprinkle chloride granules leave for 5-10 min. Scoop with brush and dust pan and discard into clinical waste bin. Mop the area with Sodium hypochlorite 1:100.

o Needles and other sharps:
Sharps must not be passed directly from hand to hand and handling should be kept to a minimum. Do not recap, bend, break, or handmanipulateused needles. Place used sharps in puncture-resistant container.

o Respiratory hygiene/cough etiquette:
Instruct symptomatic persons and health care workers to cover their mouths/noses when coughing or sneezing, use and dispose of tissues, perform hand hygiene after hands have been in contact with respiratory secretions and wear surgical mask if tolerated or maintain spatial separation, >3 feet if possible.

ii. Transmission-Based Precautions:

- apply to selected patients, based on a suspected or confirmed clinical syndrome, a specific diagnosis, or colonization or infection with epidemiologically important organisms.
- are to be implemented in conjunction with standard precautions.
- Three types of transmission-based precautions have been developed; airborne, droplet and contact.
- Few diseases (e.g. varicella, influenza) may require more than one isolation category.
- Essential elements of each isolation category are outlined below;

- **Airborne Precautions**

  Designed to prevent the transmission of diseases by droplet nuclei (particles <5 μm) or dust particles containing the infectious agent. These particles can remain suspended in the air and travel long distances. If the particles are inhaled, a susceptible host may develop infection. Airborne precautions are indicated for patients with documented or suspected tuberculosis (pulmonary or laryngeal), measles, varicella, or disseminated zoster.

  Patient Placement In descending order of preference;

  1. Negative pressure room en-suite bath

  2. Single room (nursed with door closed) and en-suite bath

  3. Single room

  4. Cohort (not recommended unless absolutely necessary)consult Physicians, paediatricians or microbiologists

  Respiratory Protection

  Wear respiratory protection when entering the room of a patient with known or suspected infectious pulmonary tuberculosis. Susceptible persons should not enter the room of patients known or suspected to have measles, rubellaor varicella (chickenpox) if other immune caregivers are available. If susceptible persons must enter the room of a patient known or suspected to have measles, rubella or varicella, they should wear respiratory protection. Persons immuned to have measles, rubellaorvaricella need not wear respiratory protection

  Face shield/eye protection- As per standard precautions

  Gloves and Hand washing- As per standard precautions

  Gown- As per standard precautions

  Patient Transport
  Limit the movement and transport of the patient from the room to essential purposes only. If transport or movement is necessary, minimize patient dispersal of droplet nuclei by placing a surgical mask on the patient.

- **Droplet Precautions**

  Designed to prevent the transmission of diseases by large particle (droplet particles >5 μm) or dust particles containing the infectious agent. Unlike droplet nuclei, droplets arelarger, do not remain suspended in the air, and do not travel long distances. They areproduced when the infected patient talks, coughs, or sneezes, and during some procedures (e.g. suctioning and

bronchoscopy). A susceptible host may become infected if theinfectious droplets land on the mucosal surfaces of the nose, mouth, or eye.

Patient Placement (No special air handling or ventilation required) in descending order of preference;
1. Single room with en-suite bath
2. Single room
3. Cohort – place the patient in a room with patient(s) who has active infection with the same microorganism but with no other infection.
4. In the general ward, but maintain a spatial separation of at least 3 feet between infected patient and other patients and visitors. Place an isolation trolley/tray* at the entrance of the isolation zone.

Respiratory Protection Wear mask when working within 3 feet of the patient. If placed in a single room, wear mask before entering the room.

Face shield/eye protection- As per standard precautions
Gloves and Hand washing - As per standard precautions
Gown - As per standard precautions

Patient Transport
Limit the movement and transport of the patient from the room to essential purposes only. If transport or movement is necessary, minimize patient dispersal of droplet nuclei by placing a surgical mask on the patient.

- **Contact Precautions**

Used to prevent the transmission of epidemiologically important organisms from an infected or colonized patient through direct (touching the patient) or indirect (touching contaminated objects or surfaces in the patient's environment) contact.

Patient Placement In descending order of preference;

1. Single room with en-suite bath

2. Single room

3. Cohort – place the patient in a room with a patient(s) who has active infection with the same microorganism but with no other infection.

4. In the general ward with an isolation tray/trolley* beside the bed.

Respiratory protection- As per standard precautions

Face shield/eye protection- As per standard precautions

Gloves and Hand washing - In addition to Standard Precautions, wear gloves (clean, non-sterilegloves are adequate) when entering the room.

During the course of providing care for a patient, change gloves after having contact with infective material that may contain high concentrations of microorganisms (fecal material and wound drainage).

Remove gloves before leaving the patient's environment and wash hands immediately with soap or a waterless antiseptic agent.

After glove removal and hand washing, ensure that hands do not touch potentially contaminated environmental surfaces or items in the patient's room to avoid transfer of microorganisms to other patients or environments.

Gown

In addition to Standard Precautions, wear a gown/apron (a clean, non-sterile gown/apron is adequate) when entering the room if you anticipate that your clothing will have substantial contact with the patient, environmental surfaces, or items in the patient's room, or if the patient is incontinent or has diarrhea, an ileostomy, a colostomy, or wound drainage not contained by a dressing.
Remove the gown before leaving the patient's environment.After gown removal, ensure that clothing does not contact potentially contaminated environmental surfaces to avoid transfer of microorganisms to other patients or environments

Patient-Care Equipment

Dedicate the use of noncritical patient-care equipment such as thermometer, stethoscope, BP set to a single patient (or cohort of patients infected or colonized with the pathogen requiring precautions).

If these items must be shared, they should be cleaned and disinfected before reuse.

Patient Transport

Limit the movement and transport of the patient from the room to essential purposes only. If transport or movement is necessary, use clean linen. Cover all open wounds before transport.

* Isolation tray/trolley must contain the following items: nonsterile gloves, non-sterile gowns, surgical masks, thermometer, BP set, stethoscope, alcohol hand rub

iii. Practice Of Isolation

- **Patient Placement**

o Appropriate patient placement is a significant component of isolation precautions.Determine patient placement based on the following principles:

- Route(s) of transmission of the infectious agent.
- Risk factors for transmission in the infected patient.

- Risk factors for adverse outcomes resulting from healthcare-associated infectionin other patients in the area.
- Availability of single-patient rooms.

- Give priority to the following types of patients /infections when single rooms are scarce
  - Source patient has poor hygienic habits, contaminates the environment, orcannot be expected to assist in maintaining infection control precautions tolimit transmission of microorganisms (i.e., infants, children, and patients withaltered mental status).
  - Source patient has uncontained secretions, excretions or wound drainage.
  - For patients with obligate or preferential airborne infections which includepulmonary tuberculosis, measles and chickenpox.

- Cohorting:
  - When single rooms are scarce patients with epidemiological and clinical information suggestive of a similar diagnosis may be allowed to share a room, but with a spatial separation of 3feet.
  - In cohorted areas minimize patient mingling.
  - For airborne/droplet transmission ask patients to wear surgical mask and ensure room is well ventilated
  - Increase the cleaning of common areas including bath / toilet facilities (e.g. 4–6 hourly).
  - Place alcohol hand rubs beside each patient bed.
  - Avoid sharing of equipment, but if unavoidable, ensure that reusable equipment isappropriately disinfected between patients
  - Isolation trolley/tray with all the necessary PPE must be available at the entranceof the cohorted area.
  - Assigning or cohorting healthcare personnel to care only for patients infected orcolonized with a single target pathogen limits further transmission of infectiousagents to uninfected patients but is difficult to achieve in the face of currentstaffing shortages in hospitals and in non-hospital healthcare sites.
- For critical / seriously ill patients: patients who will require close monitoring, isolationrequirements should not compromise clinical care. For such patients the options are
  - Arrange for intensive monitoring (equipment / personnel with appropriate PPEs)to be placed in the isolation facility or
  - Bring patients out into open area with cohorting requirements (only if themode of potential spread is contact / droplet)

- **Signs, BHT, Isolation Tray And Trolley**

o Place appropriate signs on the door/ patient screen/bed stand to indicate the type of isolation precaution required for the patient.

o The case records, X-rays and observation charts must not be taken into the isolation room or cohorted areas.

o An isolation tray/trolley is required to be placed outside each isolation room/ area, unless an ante room with adequate storage facilities is available.

- **Equipment And Supplies**

o As far as possible, dedicate the use of non-critical patient care equipments such as thermometer, BP set, stethoscope to a single patient.

o Non-critical items, such as commodes, intravenous pumps, and BP sets, must be thoroughly cleaned and disinfected prior to use on another patient.

o All disposable supplies or items that cannot be cleaned must be discarded when the patient is discharged from the isolation rooms.

- **Visitor Policy For Infection Control**

o The support offered to patients by visitors is of great importance in their recovery and wellbeing. A few simple principles will ensure the visitor's and the patient's safety from exposure to communicable diseases.

  - Visitors are discouraged from entering isolation rooms of patients in airborne anddroplet isolation. They are expected to wear the same PPE that a health careworker would wear performing the same activity.
  - All visitors who are involved in caring of patients should be educated on standardprecaution, which include use of PPE and hand hygiene. This applies to activitiessuch as such as changing bed linen, bathing or toileting.
  - Patients and family member/guardian must be counseled and given emotionalsupport.
  - In outbreak situations unnecessary visits should be discouraged. Those whochoose to visit should wash their hands as they enter and leave the area andcomply with all other hygiene practices in place. Alternative ways of communicatingwith the patient during this time include telephone and written notes.
  - Visitors with uncontrolled symptoms of coughing, sneezing, or diarrhea shouldrefrain from visiting.

- **Dishes, Glasses, Cups, Eating Utensils And Medications**

o No special precautions are needed for dishes, glasses, cups, or eating utensils.

- The combination of hot water and detergents used in hospital dishwashers is sufficient to decontaminate dishes, glasses, cups, and eating utensils. If hot water or adequate conditions for cleaning utensils and dishes are not available, disposable products should be used.
- Any medications/IV solutions, tube feedings or baby formula taken into an isolation room that is not used must be discarded when patient is discharged.

- **Transportation Of Patients**

- Limit the movement and transport of patients who require isolation and ensurethat such patients leave their rooms/isolated areas only for essential purposes.
- When patient transport is necessary, it is important that, appropriate barriers (e.g. masks, impervious dressings) are worn or used by the patient to reducethe opportunity for transmission of pertinent microorganisms to other patients,personnel, and visitors and to reduce contamination of the environment.
- Any patient with a draining wound or skin lesions should be dressed with a cleanhospital gown before leaving the room. Cover all open wounds before transport.
- Personnel in the area to which the patient is to be taken must be notified of theimpending arrival of the patient and of the precautions to be used to reduce therisk of transmission of infectious micro-organisms.
- Procedures for these patients should be scheduled at times when they can beperformed rapidly and when waiting areas are less crowded
- Use routes of transport that minimize exposures of staff, other patients andvisitors

- **Cleaning**

- Isolation rooms are to be cleaned daily.
- Cleaning MUST precede disinfection. Items and surfaces cannot be disinfected ifthey are not first cleaned of organic matter (patient excretions, secretions, dirt,soil, etc.).
- To avoid possible aerosolization of ARD pathogens, damp cleaning (moistenedcloth) rather than dry dusting or sweeping should be performed
- Horizontal surfaces and dust collecting areas, sites in the immediate patientenvironment, sites HCWs often contact should be cleaned regularly and ondischarge.
- To facilitate daily cleaning, keep areas around the patient free of unnecessarysupplies and equipment.
- Do not spray (i.e. fog) occupied or unoccupied rooms with disinfectant. This is apotentially dangerous practice that has no proven disease control benefit.

- To facilitate cleaning, and to reduce the potential for aerosolization caused byuse of a vacuum cleaner, isolate patients in uncarpeted rooms/areas.
- Upon discharge of the patient, isolation rooms will receive terminal cleaning.

4.11 Medical Records

4.11.1 Documentation of Clinical Care

i. Clinical management of all patients shall be recorded and documented in the outpatient card, case notes or computerised system and shall be updated upon completion of examination by the attending hospital personnel.

ii. All documents related to patient management including laboratory results, X-Rays, nursing care plan, observation charts etc shall be compiled along with the case notes and kept current.

iii. Documentation of clinical care shall be maintained by hospital personnel attending to the patient and each entry shall be dated, initialled and stamped.

iv. All amendments made must be clearly cancelled and initialled by the respectiveHospital personnel. Entries shall not be deleted by corrective fluid.

vi. Management of Patient Medical Record shall be in accordance to *Pekeliling Ketua Pengarah Kesihatan 17/*2010 *Garis Panduan Pengendalian dan PengurusanRekodPesakit di Hospital-hospital danInstitusiPerubatan*dated June 2010.

4.11.2 Security and Confidentiality of Medical records

i. Patient's file shall be sent to the Record Office within 72 hours after discharge.

ii. All medical records in the wards shall be kept at locked cabinet/room/bag except for current used records.

iii. All medical records for potentially medico-legal cases shall be kept locked in the 'bilikKebal'. In the event it has to be referred to, the photocopied copy shall be used except during the internal and external inquiry.

iv. All medical records for present patient use shall be in the custody of the ward Nursing Sisters.

v. In the situation where the medical records is borrowed other than for the use of admitted patient, the borrower shall solely hold the responsibility over the safety of medical records.

vi. In the event medical record is lost, police report shall be made by the person responsible at the time of lost.

vii. All patients' medical records should be transported in locked bag and the person holding the bag shall not have access to the key to avoid tampering of records.

viii. All medical records shall not be brought out of the hospital complex.

ix. All the borrowing and return of medical records shall comply with the required procedures.

x. No photograph shall be taken from the medical records.

xi. Photocopying of medical records is strictly not allowed except with the approval of the Hospital Director or by order of court.

4.11.3 Duration of patient medical records keeping

All patient medical records are held by the hospital for a period of 7 years for non-medico legal cases and 21 years for maternal &paediatric cases from the last time it was activated. For psychiatric cases, the medical records must be kept until 3 years after the death of the patients.

4.11.4 Records for specialist clinics

The One Stop Counter holds their own records for outpatient (specialist clinics). Active records are stored at the One Stop Counter. Passive records are stored up to seven years at the supplementary store.

The Medical Records Department holds all inpatient records.

4.11.5 Medico-legal Emergency and Trauma Department records

Emergency and Trauma Department records classified under Medico-legal purposes are collected by the Medical Records Department on a weekly basis or sent to Medical Records Department on daily basis.

4.11.6 Dispatch of medical records

Authorized dispatch attendants dispatch medical records within the hospital using secured dispatch bag. Bringing of medical records out of the hospital is strictly forbidden, except for viewing by a court of law.

4.11.7 Release of patient information

- Information about a patient can only be released with the consent of the patient or the guardian if the patient is under aged or unfit, or the next of kin if the patient has died. However, information cannot be released without the prior knowledge and approval of the Hospital Director. However in his absence, permission has been given to the AMRO who will act according to his or her discretion.
- Information about patient can be released to authorized body without consent of patient or relatives.

4.11.8 Medical Report

i. Medical report shall be prepared on receiving written request from the patient or authorized person. The medical report shall be prepared with reference to the content in the patient's medical record.

ii. Medical report shall be prepared by a Medical Officer or Specialist in the respective discipline involved in the care. The report shall be prepared within 4 weeks.

iii. A medical report that has been officially released shall not be altered or tampered. Any party i.e. patient, lawyers or insurance company may request for verification when there is suspicion of tampering of the medical report. The hospital shall verify that it is 'similar' or 'not similar' to the original report released by the hospital.

iv. Medical report of medico-legal or potential medico-legal cases shall be prepared by the doctor/specialist managing the case and verified by the head of the department before release.

v. Medical report shall be charged in accordance to the Fees Act 1982 / its amendment or in accordance to the Ministries circulars. The charge is based on the complexity of report and range between RM40 – RM1000 for citizens.

vi. Existing guideline *"Pekeliling KPK Bil. 16/2010: Garispanduan Penyediaan Laporan Perubatan di Hospital-Hospital dan Institusi Perubatan"* shall be complied in the preparation of Medical Report.

4.11.9 Medical Statistics

i. Data and statistics to be collected shall be as specified by the Ministry or the Medical Record Committee of the hospital.

ii. The respective department and unit shall submit monthly data to the medical record unit by the 5th of the following month.

iii. Request for medical data and statistics of the hospital shall be done through the medical record unit and release is subject to the Hospital Director's approval.

4.11.10 Medical Board

i. Medical Board is established under **eight (8)** circumstances, according to *Buku Garispanduan Penubuhan Lembaga Perubatan Di Jabatan Kesihatan Negeri, Institusi Perubatan& Hospital-hospital Kementerian Kesihatan Malaysia* published June 2010 page 2 and 3.

ii. All Medical Board application must be through State Health Office.

iii. Application with the purpose of termination of an officer due to medical reason shall use the form Lampiran A (P.P 10/1995) and sent in together with the required documents. Application for other circumstances than those in *GarispanduanPenubuhanLembagaPerubatan* shall be sent in written according to the reasons.

iv. Medical Board panel must include at least 2 specialists whereby one of them is a specialist in the related discipline and shall be chaired by Hospital Director / Deputy Director (Medical) / Head of Department. A medical officer or specialist who has been involved in treating the patient shall not be appointed as one of the Medical Board members. The patient shall be present during the meeting. In some circumstances, the Board can allow exemption of the patient to be present during the meeting.

v. The Medical Board report shall use the format as in *Buku Garispanduan Penubuhan Lembaga Perubatan*. The report must have three copies; two copies to be sent to State Health Office and one copy to be kept in the respective hospital. The report shall be ready within six months from the application date.

vi. The application for Medical Board shall be charged in accordance to the Fees Act 1982. Refer to: "*Pekeliling PKP Bil.18/2010 Garispanduan Penubuhan Lembaga Perubatan di Jabatan Kesihatan Negeri, Institusi Perubatan dan Hospital-hospital Kementerian Kesihatan Malaysia".*

4.12 QUALITY

4.12.1 Responsibility on service quality

i. The hospital shall have overall responsibility to ensure the development, implementation and monitoring of service quality, through the Accreditation Committee, Patient Safety Committee, and the Quality Assurance and Training Unit, which provide for a systematic review of the quality and effectiveness of services rendered. The various committees shall meet accordingly as spelt out in the terms of reference.

ii. Every departments and units in the hospital shall be responsible for the provision of quality and safe service.

4.12.2 Standards and Indicators

i. The National Indicators, Key Performance Indicators, National Key Result Areas shall be used to monitor the hospital performance in quality care.

ii. All cases of shortfall in quality (SIQ) shall be investigated to find out the cause and to carry out remedial action.

iii. The hospital shall establish its own specific indicators for monitoring quality within the department and unit.

4.12.3 Quality Improvement Activities

i. Quality improvement should be planned, implemented and evaluated for any Short Fall in Quality or Opportunity for Improvement identified. Quality improvement should be a regular agenda of all departmental or ward meeting.

ii. The following quality activities shall be implemented:

- Malaysian Patient Safety Goals
- Quality Assurance studies
- Incident reporting
- Client Charter
- Client Survey
- Clinical audit
- Nursing audit
- Mortality and morbidity review
- 5S
- Annual Accreditation self assessment and assessment by internal surveyor
- Quality improvement projects

iii. All activities on quality improvement shall adhere to existing MOH guidelines and procedures (e.g. SPKPK Bil.2/1999 Ministry of Health Policy on Accreditation of Healthcare Facilities and Services dated10 June 1999)

4.12.4 Review methods and procedures.
Other appropriate review methods and procedures shall also be in place to ensure that patient care resources are utilized effectively and efficiently.

4.13 TRAINING

4.13.1 Staff Credentialing & Privileging

i. Credentialing and privileging process shall be complied with.

ii. Hospital privileging Committee shall sit to decide on the approval for privileging application on a regular basis.

iii. Staff credentialing & privileging will be implemented based on the following guidelines:

a. "Guidelines For Credentialing and Privileging in the Ministry of Health, Malaysia, February 2001"
b. "Credentialing and Privileging of Allied Health Professionals, Ministry of Health, Malaysia, 2006"

iv. All non-government medical practitioners practicing in the hospital as locum, training attachments or on sessional basis shall be required to obtain a written approval to practice in the facility, from the Director General of Health in accordance to Section 34C of the Medical Act 1971. They shall be privileged.

v. Refer to (i) *SPKPK Bil.11/2008 Panduan Penggunaan Khidmat Doktor Swasta Untuk Perkhidmatan di Klinik Kementerian Kesihatan (Hospital dan Klinik Kesihatan) dengan Kadar Baru RM80 sejam* dated 24 August 2008,(ii) *SPKPK*

Bil.4/2001 Garis Panduan Pengambilan Pakar Swasta untuk Berkidmat di Hospital-hospital Kerajaan dated 22 February 2001.

4.13.2 House Officer Training

The house Officer training should be guided by 'Buku Panduan Program Pegawai PerubatanSiswazah Edisi 2012' and any latest revised guidelines. The House Officer Training Committee shall be met regularly to discuss matters pertaining to individual house officer or the training as a whole.

4.13.3 In Service Training and Research

i. Program for human resource development
The management shall develop a program for human resource development. The training program shall include:
   a. orientation for all newly appointed staff
   b. lectures, clinical presentations and in service training.
   c. refresher courses.

ii. Minimum requirement of training
The management shall ensure that the minimum requirement of training (i.e. 7 days per year per staff) for all categories of staff is complied with. The point system for Continual Professional Development shall be implemented for all categories of staff.

iii. Research activities
The management encourages research activities in particular clinical and operational research. The Clinical Research Centre was set up to oversee the clinical research activities in Sibu Hospital.

4.14 Occupational Health and Safety Policy

- The hospital occupational health and safety policy aims to provide a safe workplace for all.
- Hospital management recognises their OH&S responsibilities and establishes OH&S standards and ensures compliance.
- A Safety Officer shall be appointed.
- The Hospital shall ensure all OH&S issues are addressed.
- OH&S matter shall be a permanent agenda in all departmental or unit meetings.
- OH&S training tailored to local risks shall be conducted regularly for all new staff and students.

4.14.1 Hospital OHS Committee

To identify hazards, assess risks and then eliminate, minimise or control the hazard. To provide any safety equipment required and ensure that safety procedures are followed. To provide supervision and training for staff/students on appropriate safety procedures.

4.14.2 Staff's And Student's Responsibility

To assist in identifying hazards and risks. To cooperate with the OH&S policies and to follow safety procedures and use safety [P.P.E.] equipment where required.

4.14.3 Incident Reports

All safety incidents, including "near misses" should be reported to QATU and the incident report should be submitted within 24 hours. Incidents involving students should be reported by the supervisor or School Office. The Senior Officer or Safety officer shall undertake investigation of each incident and ensure that remedial measures are taken.

All incidents & near misses are to be systematically documented. A summary report should be forwarded to Hospital Director.

4.14.4 Sharp Injury

a. Policy Statement

The Ministry of Health aims to create awareness, reduce sharps injury and mucosal exposure to a reasonably practical level. Should an exposure occur, ensure timely and appropriate management of the exposure to reduce the risk of blood-borne pathogens to the affected employee.
Needle stick and sharps injuries will be managed by the Infection Control Unit. There should be a clear designation of responsibilities in each facility. All information must be made known to all staff.

i. Definitions

- **Sharps injury** can be defined as injury from needle or other sharp device contaminated with blood or a body fluid and penetrates the skin percutaneously mucosal/ cutaneous exposure.
- **Blood borne pathogens** are viruses that some people carry in their blood and which may cause severe disease in certain people and few or no symptoms in others. The virus can spread to another person even if the carrier is asymptomatic. The main blood borne viruses of concern are:
    - Hepatitis B virus (HBV)
    - Hepatitis C virus (HCV)
    - Human Immunodeficiency Virus (HIV)

- Source patientis the person whose blood is present on the item that caused the sharps injury.

b. Responsibilities

i. Hospital Director

Hospital Director is responsible for implementing this policy in the hospital. They must ensure that all employees are aware of this policy and of their responsibilities contained therein.

ii. Doctor In-Charge

Doctor in-charge (other than the affected HCW) will be responsible for:

- Obtaining informed consent from the source patient for HBV and HCV blood/ HIV tests.
- Taking a 5ml blood sample from the source patient and sending it to the serology laboratory in microbiology for HBV,HCV and HIV.
- Ensure immediate first aid has been administered to healthcare workers.
- To inform doctor in-charge/ infectious disease physician/ infection control unit as soon as possible if the source person is at risk or has been diagnosed with Hepatitis B, Hepatitis C or HIV.

iii. The Roles Of The Infection Control /Occupational Health Unit

The roles of the Infection Control /Occupational Health Unit are:

- To disseminate information throughout the hospital regarding the prevention and immediate management of sharps and needle stick incidents.
- To ensure the timely and appropriate management of sharps and needlesticksincidents as and when they are reported to the Infection Control Unit.
- To notify all sharps injury in reference to “Sharps Injury Surveillance Manual 2007”

iv. The Roles Of The Infectious Disease / General Physician

The roles of the Infectious Disease / General Physician are:

- To assess the blood-borne viruses pathogen exposure risk to healthcare workers.
- To assess Hepatitis B immunisation status of healthcare workers.

- To support injured staff by counseling affected employees and by co-coordinating longer term follow-up as necessary.
- To provide all necessary vaccinations and treatment, blood tests or referrals asappropriate.

v. Employees

Have an individual responsibility to ensure that sharps are always handled safely, disposed off correctly and safely and should be aware that it is an offence (under OSHA) to discard an item in such a way as to cause injury to others. They should:

- Follow the sharps injury management guidelines and reporting arrangements found in Ministry Of Health "Guidelines on Occupational Exposures 2007".
- Report all needles tick incidents/ percutaneous exposures to the Occupational Health/ Infection Control Unit and ensure that they complete needle stick injury reporting forms (see Sharps Injury Surveillance Manual 2007)

c. Training

All new employees must attend an infection control briefing which includes

i. The risk associated with blood and body-fluid exposure

ii. The correct use and disposal of sharps

iii. The use of medical devices incorporating sharps protection mechanisms

4.14.5 Arrangements

All staff upon entry to a health organisation should be screened and offered immunization against Hepatitis B. This should be under jurisdiction of occupational health unit / staff clinic.

For the safe use and disposal of sharps, the following practices for the prevention and avoidance of needle stick and sharps injuries should be fully adopted by all health care workers who handle sharps. They should ensure that:

- Sharps are not passed from hand to hand.
- Handling of sharps is kept to a minimum.
- Needles are not broken or bent before use or disposal.
- Syringes or needles are not dismantled by hand and are disposed of as a single unit.(special setting -dental).
- Needles are never re-sheathed/recap by hand.

- Staff takes personal responsibility for any sharps they use and dispose of them in a designated container at the point of use. (You Use, You Throw).
- Sharps containers are not filled by more than three quarter and are stored in an area away from the public (especially out of reach of children).
- Sharps containers must be adequate and strategically placed. It should be consistent with work process. As far as possible it should be as close to point of use.
- Safety devices should be considered whenever possible.
- Staff should be aware of this sharps injury policy.
- A flow chart for needle stick injury shall be displayed in all rooms where needles are used.
- A bio-hazard risk of a patient for any procedure shall always be indicated by the requesting unit on the requesting form so that the radiology staff shall take necessary action and observe standard precaution as in 3.1

4.14.6 Monitoring

The Occupational Health / Infection Control Unit will generate incident statistics relating to sharps and needle stick incidents, and investigate trends or specific incidents as appropriate. Further details are available in Sharps Injury Surveillance Manual, MOH 2007

4.14.7 Environmental Safety

- Essential lightings shall be provided in the hospital
- The floors & walking pathways shall be even and clutter free.
- Warning signage should be displayed if the floor is wet or slippery.
- All rooms must be well ventilated.

4.14.8 Chemical & Cytotoxic Safety

a. Labels
Make sure all chemicals and cytotoxic drugs are correctly labeled in the workplace. Read the label and ask if you're not sure.

b. Safety Data Sheets (SDS)†
Provide all safety information from the SDS to employees. Take all precautions advised on SDS.

c. Safe Operating Procedures (SOP)
Provide SOP for all employees using chemicals and cytotoxic drugs. Comply with SOP for handling, using chemicals and cytotoxic drugs.

d. Training
Training must include safe use of emergency procedures and first-aid treatment in case of accidents involving chemicals and cytotoxic drugs. Follow the procedures taught in training.

e. Supervision
Ensure that adequate and regular supervision is carried out with employees using chemicals and cytotoxic drugs. Comply with supervisors instructions and report to supervisor of any injury, defect or hazardous situation.

f. Personal Protective Equipment (PPE)
Provide and replace all necessary PPE as recommended by the manufacturer of the chemicals and cytotoxic drugs. Wear the PPE provided when appropriate and look after it when not in use. Report any PPE defects.

4.14.9 Radiology Safety

Radiological safety (Term Of Reference: Code of practice For Radiation Protection (Medical X-ray Diagnosis)-MS 838 and Atomic Energy Licensing Act 1984-Act: 304)

a. Protection of Personnel

i. Every staff shall observe radiation protection policy as outlined in the Code of Practice and the Malaysian Standard for Radiation (MS 838).

ii. Only those staff required to assist, or in the course of training, should be present during the performance of x-ray examination.

iii. Every staff required to be present during the x-ray examination shall wear a lead apron having a lead equivalent of not less than 0.25 mm, and shall not remain any closer to the patient and x-ray tube than necessary. A double-sided apron should be worn by personnel who may receive radiation posteriorly and laterally as well as anteriorly.

iv. No person shall hold a patient, x-ray film cassette, other imaging device or x-ray tube head in position during exposure unless it is otherwise impossible to obtain a diagnostically useful image.

v. Motion restricting devices shall be applied to the patient insofar as it is practicable; and devices for remote holding of the film cassette shall be used wherever feasible.

vi. Any person holding the patient or the film cassette in position during exposure shall wear the lead apron and wherever practicable. They should ensure as far as practicable that no part of their body, even if covered with protective clothing, is in the useful beam

vii. For special procedures, specialists in radiation protection should be consulted regarding requirements on radiation safety.

viii. Radiologist and radiographer shall have their medical surveillance every two years and every five years for other personnel.

b. Environmental Safety

i. Warning signs and lights should be installed at entrances to X-ray rooms. All entrances to the X-ray room shall be marked with a sign as shown in fig. 1 to warn the presence of X-rays. All entrances to X-ray rooms shall have a light that is illuminated prior to exposure or when fluoroscopy is in progress. The warning light should be red in colour but yellow or amber may be used.

ii. Secondary protective barriers shall be provided in all walls, ceilings and floor areas not having primary barriers. All barriers shall have a minimum height of 2 m above the floor.

iii. Doors and windows shall have the same lead equivalence as that required for the wall. If the X-ray room is located above the ground floor, a protective barrier of 1.5 mm lead equivalence in thickness and 1.2 m by 2.5 m in area shall be provided in the floor area beneath the X-ray examination table.

iv. All x-ray machines shall be regularly inspected by qualified personnel in accordance with Atomic Energy Act 1984 and Radiation Protection Regulations 1988.

v. All rooms shall have adequate lightings.

vi. Floors shall have even surfaces and warning signage shall be displayed for wet floors.

c. Chemical Safety

i. A darkroom personnel shall observe all the necessary precautions required in handling corrosive chemicals(photographic chemicals).As far as practicable a suitable attire shall be worn by the personnel during preparation of photographic solutions(developer and fixer).The suitable attire includes plastic apron; rubber glove and face mask.

ii. A suitable attire as in 2.1 shall be worn by the darkroom personnel during washing and cleaning of a film processor.

4.15 POLICY ON SUSPECTED CHILD ABUSE AND NEGLECT

Sibu Hospital adopts the Guidelines for the Hospital Management of Child Abuse and Neglect by Medical Development Division, Ministry of Health, Malaysia (February 2009):

4.15.1 Hospital Accountability in child abuse and neglect are:

a. Identification of the abused child
b. Diagnosis and documentation
c. Provision of a safe environment while medical evaluation and social assessment is taking place
d. Treatment of any injuries and mental health assessment / counseling
e. Drawing up a management plan in consultation with Social Welfare Department and /or Police, prior to discharge
f. Follow up and review
g. To provide coordination amongst the various agencies in case evaluation, management and reporting

4.15.2 Suspected Child Abuse and Neglect (SCAN) Committee

Formation of Suspected Child Abuse and Neglect (SCAN) Committee, in partnership with various governmental agencies, and the members shall consist of at least various relevant medical specialists, allied health professionals, police, social welfare officer.

4.15.3 The functions of SCAN Committee are:

a. To develop and review hospital policies and procedures for the handling of suspected or actual cases of child abuse &/or neglect
b. To maintain a database on the cases handled by the team
c. To provide and organize echo training for the hospital and the community
d. To enhance community awareness on the prevention and reporting of SCAN cases

4.15.4 Informing a Child Protector

Under Child Act 2001 (Section 27(1)), if a medical officer or a registered medical practitioner believes on reasonable grounds that a child he is examining or treating is physically, or emotionally injured as a result of being ill-treated, neglected, abandoned or exposed, or is sexually abused, he shall immediately inform a Child Protector (in Social Welfare Department).

4.15.5 Multi-Disciplinary Approach

a. Ensure all relevant departments (inclusive but not limited to Paediatrics, Medicines, Obstetrics &Gynaecology, Psychiatry, Emergency & Trauma, all Surgical Disciplines) and allied health professionals (inclusive but not limited to Medical Social Worker, Psychology) within the Hospital to

develop protocol for handling cases of actual and suspected child abuse and/or neglect through:

b. The designation of appropriate / senior medical and nursing staff as the responsible agent for dealing with such cases;

c. The development and implementation of procedures to be followed by departmental staff (which shall include mechanism of reporting to the Police / Social Welfare department and procedures which support follow up by Social Welfare Officers and investigation by Police); and,

d. The development and maintenance of clear lines of communication and responsibility with the other agencies involved both in the immediate community, and with referral institutions elsewhere.

4.15.6 Multi-Agency Approach

All agencies involved in the investigation of child abuse and neglect are encouraged to use a multi-disciplinary approach whenever possible. The goal of this approach is to reduce trauma to children, improve coordination of service delivery, ensure forensic defensibility of services (i.e. medical examination and interview components), and enhance the court's ability to protect families.

4.16 BREASTFEEDING POLICY

4.16.1 Sibu Hospital Breastfeeding Policy

All health staff must be aware of the written Sibu Hospital Breastfeeding Policy and be able to inform the public on its implementation.

4.16.2 Training of Hospital Staff

We would train all hospital staff involved in the care of mothers and infants so that they have skills to implement our policy.

4.16.3 Education On Breastfeeding for All Mothers

We would give regular education to all antenatal mothers on the benefits of breastfeeding and the management of breastfeeding.

4.16.4 Implementing Breastfeeding

In accordance with the Malaysian Breastfeeding Policy, all mothers are encouraged to exclusively breast-feed their infants for the first six months of life and to continue breastfeeding until the age of 2 years. Complementary foods need to be introduced at the age of 6 months.

4.16.5 Early Initiation of Breastfeeding

Our staff would place babies in skin-to-skin contact with their mothers immediately following birth for at least 30 minutes, although the recommended duration is up to 1

hour. Our staff would also help mothers recognize when their babies are ready to breastfeed, offering help if needed.

4.16.6 Showing Mother How to Breastfeed and Maintain Lactation
Our staff would show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants because of other medical reasons.

4.16.7 Exclusive Breastfeeding

No food or drinks other than breast milk are to be given to newborns in our wards unless medically indicated. Group instructions and promotion of breast milk substitutes are not allowed in this hospital. The latest Malaysian Code of Ethics for "The Marketing of Infant Foods and Related Products" shall be adhered to by all staff.

4.16.8 Rooming-in for Breastfeeding Mothers
We would provide rooming-in facilities to allow mothers and infants to remain together 24-hours a day, so that breastfeeding is not interrupted.

4.16.9 Breastfeeding On Demand
We encourage all mothers to breastfeed on demand so that milk production can be maintained.

4.16.10 No Artificial Teats or Pacifiers are Allowed
We do not give artificial teats or pacifiers to breastfeeding infants because they can cause nipple confusion.

4.16.11 Ongoing Help Through Breastfeeding Support Group
Mothers who are being discharged would be provided with written information on ongoing support of breastfeeding. We encourage all mothers to freely seek help from our Hospital Post-natal Ward (Ward 5) staff (Tel: 084-343333 Ext 6021) or the local Maternal-and-Child Health Clinic staff.

4.16.12 Mothers with HIV Infection
These mothers will be given the appropriate advice, counseling, support and care to reduce mother-to-child transmission, which shall include appropriate advice on infant feeding. The latest circular for "Baby born to mother with HIV" shall be adhered to by all staff.

4.16.13 Mother Friendly Care
We would help all women to feel competent, in control, supported and ready to interact with their baby and implement practices that would enable all women to achieve mother friendly care.

4.17 ORGAN, TISSUE, CELL DONATION &TRANSPLANT POLICY

4.17.1 Organ, tissue and cell donation should be promoted among staff and patients in the hospital.

4.17.2 The transplant shall be performed in accredited centre and accredited personnel.

4.17.3 Organ transplantation shall be promoted as the preferred treatment for end-stage organ failure because it is cost-effective and it provides good quality of life. Similarly tissue and cell transplantation shall be promoted for the treatment of appropriate diseases where evidence of effectiveness exists.

4.17.4 The Tissue Organ Procurement (TOP) Team consisting of trained personnel who shall be responsible for the identification and management of the potential donor including getting consent from the next of kin, evaluation for donation, organising the procurement, storage and transport of the organs and tissues and speedy return of the donor's remains to the next of kin.

4.17.5 Prior consent from the family of the suitable organ/tissue/cell cadaveric donor shall be obtained prior to procurement.

4.17.6 In cases where potential cadaveric donors' remains are being held under the Criminal Procedure Code for post-mortem or coronal inquest, prior written consent from the magistrate has to be obtained before any organ and/or tissue procurement is carried out, in accordance with the existing legislation.

4.17.7 Full respect shall be given to the dignity of the cadaveric donor.

4.17.8 The donor shall be exempted from all medical cost and the family shall not borne any cost of procurement.

4.17.9 Confidentiality regarding the identity and personal details of donors and recipients shall be ensured.

4.17.10 All clinicians involved in the procurement and transplantation process shall ensure the highest standards of safety and quality.

4.17.11 Unrelated living organ donation shall comply to the MOH guidelines (MOH/P/PAK/ 221.11(BP)).

4.17.12 All living organ donors shall be followed up for life.

4.17.13 Hospital shall facilitate those who desire to involve in either private or public Cord Blood Banking programme.

4.18 Policy of Withholding and Withdrawer of Life Support Therapy

4.18.1 Ethical Principles of Withholding and Withdrawal of Life Support Therapy

a. Beneficience
b. Non-malefficence
c. Autonomy
d. Social Justice
e. Trustworthiness

4.18.2 Capacity and surrogate decision-making

a. Clinicians should assess patient's decision-making capacity. This should include patient's ability to comprehend, appreciate, rationalize, and express his choice of treatment.

b. If patients do not have decision-making capacity, the families become the surrogate decision-makers. However the decision foe end-of-life is a medical decision made by clinicians with the concurrence by family members.

4.18.3 Autonomy and obligation to treat

a. Patient autonomy must be respected after establishing decision-making capacity. In cases of refusal of treatment, a patient's wishes shoulde be respected although it may result in death.

b. In cases of medical futility, clinicians are not obliged to initiate or continue life-sustaining therapy.

4.18.4 Respect for the dying

All dying patients should be afforded the same standard of care as other patients.

4.18.5 Medical Team Consensus

The ICU team and the primary team should ideally agree on end-of-life decisions

4.18.6 Communication with patient and relatives

a. The discussion on end-of-life decisions should be made with the patient if he/she has decision making capacity.

b. It is best that the same clinician who is involved in the active care of the patient deals with the family. This clinician is someone who has been frequently communicating with family. A witness should be present.

c. In the event of disagreement, allow:

- Time limited trial of therapy with definite goals
- Second medical opinion
- Facilitation by a third party eg spiritual advisor
- Patients and family must be given sufficient time to reach decisions at the end-of-life

4.18.7 Management plan for withdrawal of life support therapy

A clear plan of management for the withdrawal of life support therapy is important to ensure that the process occurs smoothly. The plan should be reviewed with the patient and family, with an emphasis on maintenance of the comfort for the patient. The plan should include the following components:

a. All forms of life support are maintained until the patient and family have had enough time together.

b. Ensure patient comfort with attention to pain control and other symptoms control.
c. Relief of pain and discomfort:
    i. Morphine is the most common opioid used for relieving pain without any maximum dose
    ii. "Double effect" of opioids- maximises the pain relief and may hasten death. This is an acceptable concept.
    iii. Benzodiazepines are also used to treat anxiety.

d. Therapies or medications that do not provide a net positive contribution to the comfort of dying patients should be discontinued eg antibiotics, renal replacement therapy, radiological examination, blood transfusions.
e. Withdrawal of vasopressors may result in immediate death and therefore it should be carried out when the family is ready.
f. There are two strategies for withdrawal od mechanical ventilation:

    i. Terminal weaning- gradually reducing the ventilator settings while leaving the endotracheal tube in situ.
    ii. Terminal extubation- removal of the endotracheal tube

g. The alarms on the monitors should be disabled and the family should be allowed to be with the patient if they choose to.
h. The patient's personal hygiene and dignity should be maintained at all times.

4.18.8 Considerations around specific therapies

a. The use of noninvasive ventilation during end-of-life care should be evaluated by carefully considering the goals of care. Non-invasive ventilation maybe used as a palliative technique to minimize dyspnoea.
b. Neuromuscular blockade should not be used as they are not beneficial for patient, and make it impossible to assess patient's level of comfort.

4.18.9 Documentation

All decisions regarding the withdrawing or withholding of treatment should be documented. This should include the basis of the decision as well as amongst whom the consensus had been reached.

5.0 DISASTER MANAGEMENT

5.1 FIRE SAFETY

5.1.1 Fire Protection & Detection System and Fire Fighting Facilities

The hospital shall ensure that the Fire Protection & Detection System and Fire Fighting Facilities are in good functioning order and are in place at all times. HSS to carry out daily monitoring of the Main Fire Alarm Control Panel.

5.1.2 Inspection, Testing & Maintenance

HSS to carry out weekly, quarterly, half-yearly and yearly inspection, testing & maintenance of the Fire Protection & Detection System and Fire Fighting Facilities as recommended by BOMBA. The Hospital Management / Fire Safety Officers or Unit Head concerned must be notified immediately should there be any impairment of the system

5.1.3 Hospital Fire Safety Officers

Hospital Fire Safety Officer shall be appointed. He shall play the role as stipulated in the Fire Disaster Plan of the hospital.

5.1.4 Ward/Unit Fire Contingency Plan

Each ward/unit shall have Fire Contingency Plan: prominently displayed Fire Evacuation Plan & Directional Signs to the exits. All emergency exits should have Exit lights on & be kept clear of objects all the time.

Each ward/unit shall have 'fire compartment' providing one-hour's protection. Potentially hazardous ones shall be provided with an additional hour's protection. As such, fire doors shall be kept closed at all times, but not necessarily locked. However, if locked due to security reason, the keys shall be made easily available (one key kept in a breakable glass panel box and another key kept at the nursing counter)

5.1.5 Training

All staff are trained & well versed with the use of Fire Suppressive Equipment & Evacuation procedures. Orientation of incoming staff & inpatients shall include fire safety measures.

5.1.6 Patient Evacuation

In the event of fire, patients shall be evacuated in accordance with the principle of horizontal, i.e. patients shall be moved horizontally, from the affected fire compartment to a non-affected compartment and if the fire continues to spread, be moved progressively horizontally until, if necessary, taken vertically down).

5.1.7 Fire Drill and Fire Certificate

To conduct Fire Drill at least once a year.And to achieve the requirement and award of Fire Certificate by BOMBA every year.

5.2 HOSPITAL DISASTER PREPAREDNESS

There shall be a disaster management plan complied by the Hospital Disaster Committee with regular update. (Refer to Hospital Disaster Plan)

5.3 FLOOD PREPAREDNESS

5.3.1 There shall be a Flood Preparedness Plan compiled by the Hospital Disaster Committee.

5.3.2 All the relevant departments shall keep the minimal stock during the rainy season when severe flood is expected.

5.3.3 There shall be contingency plan for power failure, failure of water and liquid oxygen supply during severe flood.

5.3.4 The list of staff staying at flood prone areas shall be updated on regular basis.

5.3.5 In the event of emergency, pick up transport shall be arranged with the assistance from the Medical Drug Store transport.

5.3.6 Transit quarters and nursing quarters shall be used to house the staff on a temporary basis as situation needed.

5.3.7 To refer to the Flood Preparedness Plan for details.

5.4 Disease Outbreak Preparedness Plan

5.4.1 Hospital shall have a Disease Outbreak Preparedness Plan and updated as required. Refer to the plan for details.

5.4.2 Staff shall be briefed on the plan and be ready at all times.

6.0 HOSPITAL SUPPORT SERVICES

6.1 General

i. The following 5 support services are privatized in accordance to the specifications in the contract prepared by the Ministry,
   - Cleansing
   - Linen
   - Waste management
   - Biomedical engineering
   - Facility engineering

ii. The administration unit with the assistance of the Hospital Engineer shall be responsible for the overall coordination of the 5 services. A Chief Liaison Officer for each service shall be appointed to monitor and coordinate all the activities and to ensure compliance to the Technical Requirement and Performance Indicators (TRPI), the Master Agreed Procedures (MAP) and the Hospital Specific

Implementation Plan (HSIP). The HSIP shall be reviewed yearly and may be amended when necessary and endorsed by the Hospital Director.

iii. The overall coordinator shall ensure that regular Engineering and Environmental meetings chaired by Hospital Director are held at least 4 times per year to discuss issues and remedial action to be taken to improve the services. The members of which comprised of liaison officers, Head of Department/Unit and the Concession Company staff.

iv. The validation committee shall be held monthly to discuss and decide on deductions for non-conformance on a regular basis.

v. The Hospital Engineering Unit is technically responsible to monitor, evaluate, verify work done and deduction to the Concession Company.

6.2 Linen and Laundry Services (LLS)

i. All linen shall be delivered in a manner, which provides full protection from contamination during handling and transportation.

ii. Clean linen already checked and folded to an agreed pattern shall be supplied according to schedule. Linen shall be transported in designated clean or soiled linen carts.

Supply of clean linen shall be on a top-up basis daily and comply with par level of each ward/ unit/ department/ OT as agreed in the HSIP. A minimum of three sets of patient's linen per bed shall be available at any one time.

iii. Soiled linen from wards, OT and other departments shall be placed in color-coded bags (Red - infected, Green - OT linen and White - soiled) provided by the concessionaire and collected at the respective areas by the concessionaire as per agreed schedule.

iv. All in-patients are to use hospital clothing except for psychiatric cases.

v. For Doctor's white coat, it shall be supplied on exchange basis at the linen store.

6.3 Cleansing Services (CLS)

a. General cleaning of departments shall be done according to the agreed TRPI, MAP and HSIP with the approved reagents.

b. The Chief Liaison Officer and Liaison Officers for CLS shall supervise the overall cleanliness of the hospital. However, individual departmental heads will be responsible for supervising the cleanliness of their respective departments.

6.4 Clinical Waste Management

a. Training of staff.
Senior staff member shall be identified to train staff on how to handle waste and monitor standards.

b. The Infection Control Officer.
The Infection Control Officer shall provide and give guidance on safe practices and procedures for handling clinical waste.

c. Hospital waste categories.
Hospital waste is categorized as clinical waste, radioactive waste, chemical waste, pressurized containers and general domestic waste. Hospital Support Services shall collect them in specific colored plastic bags to the respective transit or disposal points.

d. Clinical waste and methods of disposal.
All clinical waste is considered as hazardous and shall be placed in yellow bags or containers. It shall be sealed when three-quarters (3/4) full and collected for incineration daily. The methods of disposing the different types of clinical waste are:

Group A	soiled surgical waste, dressings, swabs, human tissues, etc., shall be placed in yellow plastic bags. Waste from infectious cases and human tissues such as placenta should be placed in double plastic bags. Incineration is the most appropriates disposal method.
Group B	sharps are to be placed in sharp containers and when these are three quarter ($^3/_4$) full, they are sealed by the hospital staff and placed in yellow plastic bags by the Hospital Support Services staff.
Group C	waste from laboratories and post-mortem rooms that are potentially infectious shall be disinfected before disposing into yellow plastic bags. If necessary the waste may be placed in light blue plastic bags for autoclaving and then sealed in yellow bags for disposal.
Group D	solid pharmaceutical waste is to be placed in yellow plastic bags and disposed off by incineration unless recommended otherwise by the manufacturer e.g. for chlorates. Small quantities of liquid pharmaceutical wastes may be diluted and disposed off through the sewerage system. Cytotoxic wastes and associated contaminated materials (syringes, needles, vials, etc.) are

	to be placed in designated containers and then put into yellow plastic bags for incineration;
Group E	used disposable bed pan liners, stoma bags, incontinence pads, etc., is to be placed in yellow plastic bags.

e. Radioactive waste.
The collection, proper labeling, handling, storage and transportation of radioactive waste shall comply with the requirements of the Atomic Energy Licensing Act 1984.

f. Chemical waste.
Chemical waste may be hazardous (toxic, corrosive, flammable, reactive) or (non-hazardous):
- Hazardous chemical waste is to be disposed off by the most appropriate means according to the nature of the hazard. Because it often has toxic or flammable properties, hazardous chemical waste is not to be disposed off in the sewerage system.
- Non-hazardous chemical waste may be disposed off along with general waste.

g. Pressurized containers.
Pressurized containers e.g. disposable aerosol is to be placed in black plastic bags and disposed off as general domestic waste.

h. General waste.
General waste my be non-hazardous (paper, food, plastic, etc.) or hazardous (glass, chinaware, knives, tubes, light bulbs, etc.);
- Non-hazardous general waste shall be placed in black bags and disposed of by the local authority.
- Hazardous general waste requires special handling. Light bulbs and fluorescent tubes shall be collected unbroken by the local authority.

i. Hospital Support Services workers.
Hospital Support Services workers shall not handle waste in unsealed or open bags and waste in light blue bags (prior to autoclaving).

Refer to Infection Prevention & Control Policies & Procedures

6.5 Engineering Maintenance Services (FEMS) and Biomedical Engineering Maintenance Services (BEMS)

a. The Concession Company shall use the maintenance request forms to document requests from the wards or departments.

b. The Concession Company shall be responsible for carrying out the agreed maintenance according to procedures recommended by the manufacturers or MOH

c. However, the regular maintenance of mechanical, electrical and medical equipment within the warranty periods shall be undertaken by the suppliers, after which it is taken over by the Concession Company.The suppliers shall rectify faults due to normal wear and tear or due to defects within the shortest possible time, with initial respond time not exceeding 48 hours. However, in the interim period the Concession Company shall do rectification works till the technician from the supplier comes.

d. The Concession Company shall rectify any breakdown within the shortest possible time as specified in the TRPI.

e. Any improvement/alteration and reimbursable works required shall be referred first to the Hospital Director for approval.

f. All departments shall maintain updated inventory of the equipment and assets in the departments. The departmental head shall ensure that the equipment are serviced regularly and maintained by the Concession Company and documented in the Kew PA card. Unit Asset shall assist in the monitoring.

7 HOSPITAL AMENITIES

7.1 Access and Parking

i. Car park shall be made available for staff and public. Only cars with hospital stickers shall be allowed to enter the staff parking area. Designated car parks for disabled patients shall be made available with easy access to clinical areas.

ii. Public transport, buses are allowed to enter the hospital ground only at designated points in line with patient friendly policy.

iii. The Hospital shall not be responsible for the safety of vehicles parked outside the staff parking area.

iv. No parking shall be allowed outside the designated areas along the access road to Emergency and Trauma Department labour ward.

v. Refer to *SPKPK Bil.10/2004 Garis Panduan Mengenai Peraturan Lalulintas dan Meletak Kenderaan di Hospital-hospital KKM* dated 15 December 2004

7.2 Staff Facilities

i. Staff facilities shall either be allocated to individuals (e.g. office room and rooms in nurse hostel) or commonly shared by all staff (e.g. rest room and staff changing room).

ii. The common areas shall be either under the responsibility of the General Administration or the specific department where it is located.

iii. Accommodations or quarters shall be provided to some staff based on service needs, availability and eligibility. On-call staff shall be given priority for approval of stay at the quarters.

iv. Staff may be approved to stay at quarters of categories varying from their grade provided they agree to pay the deposit accordingly.

v. The Housing Board reserves the right to withdraw the approval of stay in any quarters when deem appropriate and in the best interest of the hospital.

vi. The offer for Houseman quarter is only limited to one year and further extension is subjected to the approval of the Housing Board.

7.3 Public Facilities

i. *Rumah Pelawat and Bilik Pelawat* shall be opened 24 hours as a rest place for patient's relatives. Those who use the place shall be subjected to the rules and regulation set.

ii. Prayer rooms shall be opened for 24 hours to the public and staff.

8.0 SUPPLIES AND ASSETS

8.1 Procurement

i. Procurement shall be strictly carried out in accordance to the current government financial procedure or Treasury Instruction.

ii. Procurement of all standard medical items such as drugs, consumables, chemical reagents shall be coordinated by the medical drug store.

iii. Procurement of non-standard items shall be done by the respective Unit.

iv. Procurement of office stationeries and other non-medical items shall be coordinated by the procurement unit and IT consumables by the Information Technology unit.

v. Purchasing of food items shall be coordinated by the catering unit.

8.2 Equipment and Pharmaceutical Supplies

8.2.1 Requirement & Specification

i. Requirement of medical equipment, consumables, drugs and pharmaceutical supplies shall be decided by the individual department/unit and coordinated by the Pharmacy Department.

ii. The respective head of the department shall be responsible for preparing the technical specifications.

8.2.2 Delivery & Supply

i. All pharmaceutical supplies shall be delivered to the medical store except for chemical reagent, which shall be sent directly to Pathology department. The supply of consumables shall be collected direct from medical store and the supply of drugs shall be collected from the satellite pharmacy.

ii. Bulky equipments shall be delivered directly to the respective end user. The end user and the Medical Store personnel shall be present to verify the delivery.

iii. Head of Department or representative shall be responsible to verify the contents, ensure compliance to the specifications and carry out testing and commissioning before signing the acceptance forms.Testing and commissioning process shall be carried out in the presence of the user, supplier and Asset Manager.

iv. Dangerous and Psychotropic Drugs shall be stored, transported, and managed only by pharmacist or staff nurses.

v. Items requiring refrigeration (temperature 2-8^{0}C) and inflammable / explosive materials shall be kept in individual storage area.

8.2.3 Equipment / Inventory List/Loaning

i. The hospital shall maintain an up-to-date equipment/inventory list. The department and unit shall also maintain its own equipment/ inventory list and the planned preventive maintenance schedule.

ii. Equipment shall not be moved or transferred another hospital without prior approval of the Hospital Director. Any movement and loaning of equipment to

another department shall comply to the Guidelines on Asset Management and documented.(Refer *Para 16 Bab 6 Pekeliling Perbendaharaan Bil. 5 Tahun 2007-Tatacara Pengurusan Aset Alih Kerajaan)*

iii. The loaning of equipment is limited to items needed immediately to ensure patient's safety and well being, including equipment used directly and indirectly for patient care. Indirect patient care equipment includes items needed to ensure the smooth, uninterrupted operations of the hospital.

iv. Loaned equipment shall be checked prior to delivery to ensure that it is operational. All returned equipment must be inspected to ensure it is operational.

v. All loan transactions are recorded in a form (*Borang Kebenaran Meminjam/ Membawa Keluar Harta Modal/Inventori-Lampiran A)* maintained by each department: the inventory number, to whom and by whom the loan was made, and the expected date of return to ensure that the privilege of borrowing equipment and supplies is not being abused and that the items are being returned in a timely manner.

vi. All hospital assets should not be brought home without approval of the respective Head of Department or Hospital Director. The possessor of the said asset shall hold sole responsibility over the security of the asset.

8.2.4 Disposal

i. Head of department shall be responsible to submit a list of equipment to be disposed / condemned to the Asset Unit.(Refer *Bab E Pelupusan –Pekeliling Perbendaharaan Bil. 5 Tahun 2007-Tatacara Pengurusan Aset Alih Kerajaan.*

ii. Equipment which has been given the certificate of 'beyond economic repair' may be disposed of in accordance to the guidelines of the Ministry of Health.

9.0COMMUNICATION SYSTEM

9.1 Telephones& Fax

i. A type 'A' PABX line (direct dialing throughout the country) and a separate direct telephone line shall be made available only for the Hospital Director.

ii. Heads of Departments/Units and Blood Bank may be provided with a type 'B' PABX line (direct dialing facilities within the same State) with the approval of the Hospital Director.

iii. All other telephone lines within the hospital shall be types 'C' (able to receive outside calls through the operator and can only dial directly within the hospital).

iv. Telephones shall be for official use only unless authorized otherwise.

v. Fax facilities shall be provided in identified areas to be shared between departments and units. Fax shall be used only when there is an urgency to send a letter or document and its use shall be monitored.

vi. A two-way radio communication system shall be in operation between the Emergency and Trauma Department and the ambulance while responding to an emergency call.

9.2 Paging

i. Doctors and officers who are on call shall be provided with pagers. The guidelines of the Ministry of Health on the paging system shall be complied with.
ii. Holders of pages must respond to any paging without delay.
iii. Holders of pages shall be responsible for its safe keeping. Any lost or damage should be reported immediately.

9.3 Nurse Call System

i. A nurse call system shall be provided within each ward as follows:
ii. Each bed head shall be linked to the control at the staff base which is equipped with a sound alarm and a light alert;
iii. The light will lit over the door outside the room or bay of the patient who has activated the system.
iv. A staff emergency call system shall be provided in staff areas within a ward to alert all staff in the event of an emergency. This system shall be used at the discretion of the staff in attendance.

9.4 Public address (PA) system

a. The public address (PA) system may be used for making important announcements and providing information.

b. The PA system may also be used for emergency call measures.

10.0 ICT POLICY

a. Adhere to Policy on ICT Security as in SPKPK Bil.13/2011 *Dasar dan Garis Panduan User Acsess Control Policy bagi Sistem Maklumat Hospital dan Klinik (HIS/CIS) KKM; Surat Pekeliling Am KetuaSetiausaha : Dasar*

Keselamatan ICT Kementerian Kesihatan Malaysia (KKM) Versi 4.0 dated 13 February 2013.

b. All preparation and provsion of services based on ICT system shall be continuously carried out without interruption that can jeopardise the security.

c. Safeguard official secrets and official information from unauthorised access.
   i. Do not put any information regarding work and patient care in sosial or other websites. The breach of which shall subject one to disciplinary action.

d. Ensure that every information is accurate and complete.

e. Ensure that only allow access to authorised users, and receiving information from reliable sources.

f. Ensure that information is readily available when needed by clients.
g. Physical security
   i. Control of physical access: use of security pass, and lock the office when going out.
   ii. Security of ICT asset: safeguard equipment and information from theft, break down, abuse and interruption of MOH activities.

h. Adhere to existing Cyber Laws:
   i. Communications And Multimedia Act 1998
   ii. Malaysian Communications And Multimedia Commission Act 1998
   iii. Digital Signature Act 1997
   iv. Computer Crimes Act 1997
   v. The Copyright (Amendment) Act 1997
   vi. Telemedicine Act 1997

i. Observe good ICT security practice
   i. Safeguard passwords and use secure passwords that combine numbers, alphabets, signs and symbols.
   ii. Frequent back up and safe keeping of important information.
   iii. Use genuine anti-virus software and update regularly.
   iv. Encrypt classified information. Use encryption when saving and sending classified information.
   v. Beware when downloading programs and files from internet.
   vi. Do not open e-mail from unknown sender to prevent virus, email spamming, worm and so on.
   vii. Do not leave computer staying on line when not in use.
   viii. Log off computer before leaving office.

j. Official e-mail address.

All staff of grade 27 and above may apply for official e-mail address through ICT unit. Staff grade 17 and above but below grade 27 require approval of Hospital Director for their applications.

11.DEPARTMENTAL POLICIES

11.1EMERGENCY SERVICE (EMERGENCY & TRAUMA DEPARTMENT)

11.1.1 Operating hours

The department is open 24 hours daily.

11.1.2 Pre hospital care, call centre and ambulance service

a. Ambulance Call

i. The department shall respond to ambulance calls (within 5 minutes) for emergencies within designated coverage area. For calls made from a distance more than 25 km away, the department shall coordinate with the nearest hospital or health center to respond to the call.

ii. All ambulances shall be equipped with adequate equipments for airway management, circulatory management, immobilization and some resuscitation drugs.

iii. An ambulance's team shall comprise of an Assistant Medical Officer, a nurse and a driver from the Emergency Department. Additional staff from other department shall be called to assist when necessary.

iv. Every request for the use of ambulance shall go through the Call Centre.

b. Call Center

i. A Call Center, which is located at the Primary Triage Area in the emergency department; shall function as a communication, dispatch and coordination center for all emergency ambulance calls and referrals.

ii. It will operate 24 hours daily and managed by a paramedical staff that will function as a call-taker and activity coordinator. Any senior medical personnel of the emergency department when required can also assume this function.

iii. All calls and applications for transport ambulance from within and outside the hospital shall be directed to the center.

iv. It will also serve for intra-hospital referral system and for communication activities between other ambulance service providers and the Hospital.

v. For medical emergencies situations in the hospital, the call center shall help coordinate response with relevant individuals or departments through a pre-agreed mechanism.

11.1.3 **Emergency care**

a. Triage

All patients attending the emergency department will undergo the triage process.

i. Primary Triage

The primary triage shall categorize 3 types of patients:

- **CRITICAL (Red)**

Patient who has or is going to develop critical impairment to any of the A-B-C-D (airway-breathing-circulation-disability) systems such that resuscitation is required.

Critical (Red) zone in general will receive and manages the critically ill patients harboring serious medical conditions or injuries. Such patients are also deemed as hemodynamically unstable.

(a) The management of the patients here covers the aspects of:
  (i) Resuscitation and stabilization
  (ii) Diagnosis of life threatening or
  (iii) Potentially life threatening conditions
  (iv) Immediate therapeutic intervention
  (v) Definitive management

- **SEMI-CRITICAL (Yellow)**

Patient who is ill but with stable vital signs and who requires a trolley as part of their management

(a) Yellow zone receives patients that are in semi-critical conditions, on trolley with hemodynamically stable conditions.

(b) Patients from this zone may need certain investigations / procedures to be carried out before decision for admission or discharge is made.

(c) Patients shall as kept as lodger in the observation ward.

- **NON-CRITICAL (Green)**

This category is designated for the seemingly stable individual. This category will be further subjected to a secondary triage process

ii. Secondary Triage

Secondary triage includes:

(a) an accurate verbal appreciation (subjective) followed by visual assessment (objective) of patient's symptomatology

(b) Measurement of vital signs & classification of physiological status.

(c) Re-categorization of patient into one of three triage codes (Red, Yellow & Green) indicating their respective level of urgency. Focused therapeutic actions will be initiated here.

A scheduled repeat assessment shall be performed for selected stable category of patients

- **Non Critical Care (Green) Zone**

a. This zone receives patients with minor/mild trauma injury or stable medical cases identified at the completion of primary triage process.

b. There shall be adequate consultation and examination rooms serving patients in this zone, assisted by a nurse or an attendant.

c. For radiology investigations and other treatment procedure require to be carried out in the other area of the Department, the assistant shall usher the patient into this respective area.

d. All stable cases will be seen not more than the time stated in the client's charter.

e. The attendants with wheel chair or trolley shall assist the movement of patients that are unable to walk due to illness or trauma, within the Emergency and Trauma Department.

5.5 Non-emergency cases should be seen at the nearest out-patient clinic.

11.1.4 **Mental illness/Psychiatric Cases**

A) Patients who are known case of psychiatric illness accompanied by the police or family members shall be reviewed and managed at the emergency department accordingly.

B) Patients who voluntarily present to the emergency department with undiagnosed behavior related problem or psychiatric illness will be reviewed in emergency department and managed accordingly.

C) All psychiatric patients referred to the psychiatric department should be seen within 30 minutes by the psychiatric medical officer after initiation by the emergency

medical officer.

11.1.5 **Asthma Bay**

(1) This area is dedicated for asthmatic patients with acute exacerbation seeking emergency medical treatment at the Emergency and Trauma Department.

(2) Only mild to moderate cases are treated here. Patient with severe asthma attacks are sent to Red zone.

(3) These patients are identified following primary and secondary triage process which utilizes critical observations, vital signs and peak expiratory flow measurements.

(4) Repeated assessment and examination including PEFR measurement by the attending doctor and/ or assistant medical officer will be conducted at the completion of each step of therapy and documented in the patient clerking sheet.

(5) Maximum duration of treatment here shall not exceed 4 hours. Consideration for admission must be made if complete relief is not achieved within this period or after therapy had been maximized here.

(6) Patients who achieve relief of symptom will be discharged at the end of therapy and appropriate medications prescribed.

(7) A referral to outpatient asthma clinic/ specialist clinic will be arranged when appropriate. For example:

(a) Suboptimal asthma control in all age groups

(b) Newly diagnosed asthma

(c) Asthma with co-morbidities

(d) Noncompliance to treatment

11.1.6 **Observation Bay**

11.1.6.1 This area is dedicated for observing selected semi critical trauma and medical patients or non-critical patients having clinical and physiological conditions that may change and/ or when admission is not seen as to be in the best interest of the patient or absolutely necessary.

11.1.6.2 Admission to this bay will be under the purview of the emergency doctor.

11.1.6.3 Admission shall be for not more than 12 hours.

11.1.6.4 The respective emergency doctor is responsible to review the patients' progress.

11.1.6.5 For cases requiring referral to another department, the response time of the team from the referred department should be less than 30 minutes after the initiation of referral.

11.1.6.6 Visitors to the observation bay are allowed during hospital visiting hours but limited to immediate family members or 2 persons at any one time. For other unscheduled visits, discretion shall be used by the personnel on duty.

11.1.7 **One Stop Crisis Centre (OSCC)**

(1) A special dedicated consultation room is available as OSCC. This consultation room will be utilized to cater domestic violence, sexual assault, rape, sodomy and child abuse cases.

(2) The staff will accompany the patient to OSCC straight from the triage station without delay.

(3) Emergency Doctor at OSCC sees all rape cases who present to OSCC within 72 hours after the event.

(4) All rapes cases who present to OSCC more than 72 hours after the event are advised and referred to the Gynecology Clinic.

(5) The Emergency Doctor in OSCC will initiate consultation and conduct physical examination and refer to other clinic or unit if required.

(6) Patients / victims will get medical treatment as well as access to other agencies or counselors if they request.

(7) Referral to Medical Social Worker (MSW) and other agencies or department will be made direct from OSCC.

(8) All Child abuse or suspected child abuse cases will be referred and admitted to pediatric ward.

(9) Emergency doctor can admit child abuse cases even without the consent from the guardian whenever deemed necessary and lodge a police report if not done earlier.

(10) Sodomy cases will be referred and manage by the Surgical Department

11.1.8 **Disaster Management**

(1) The department shall be equipped and prepared to provide emergency medical response during disasters occurring externally or within the hospital facility.

(2) The Emergency and Trauma Department shall see to the deployment of a search and rescue team (s) during disaster response.

(3) The hospital shall also response to any regional request for emergency medical assistance in the event of disasters or major incident.

(4) The Emergency and Trauma Department shall also assist the transportation of patients during disaster situations.

(Refer to Hospital Disaster Plan)

11.1.9 **Medical Coverage**

11.1.9.1 Medical coverage will be as set by the Ministry of HealthGuideline**.**

11.1.9.2 All requests for Medical Coverage shall require approval from the Hospital Director before any team can be dispatched.

11.1.9.3 The provision of emergency service in the department will be given priority over the provision of medical coverage.

11.1.9.4 Risk assessment of events will be performed before any deployment of a medical cover team.

11.1.9.5 A team trained in various aspects of medical coverage shall be deployed during such medical coverage activities.

11.2 **SPECIALIST OUTPATIENT SERVICE**

Provides consultation for new referrals from polyclinics, private doctors, and other government hospitals. Follow-up of the patients with chronic illness and also those discharged from the wards

- Patients are seen by appointment.
- Standby cases are only allowed after obtaining prior approval from the receiving specialist.
- To make an appointment, one can come in person, telephone booking by doctors / nurses, via facsimile or online appointment for TPC clinics/hospital
- New referral case needs a referral letter to make an appointment.
- Fees will be charged according to Fee Acts.

11.3 **DIAGNOSTIC IMAGING DEPARTMENT (RADIOLOGY)**

11.3.2 **Scope Of Service**

a. Services available

Provision of diagnostic imaging services for in-patient and out-patient, of all age groups and disciplines, are as follows :-

i. Plain Radiography

ii. Water soluble contrast studies:

Intravenous Urography, MitcturatingCystourethrography, Antegrade Pyelography, Retrograde Pyelography, Retrograde Urethrography, T – Tube cholangiogram, Percutaneous TranshepaticCholangiogram, Gastrografin studies, Sinogram / Fistulogram, Sialography, Upper Limbs and Lower limbs Venography, Myelogarphy, Hysterosalphingography, Genitography, Dacrocystography*, Bronchography*.

iii. Barium Studies:Swallow, Meal, Follow-through, and enema. Small bowel enema*.

iv. General Ultrasonography (not ophthalmological or cardiac)

v. Colour Doppler Ultrasound.

vi. Conventional tomography

vii. Computed tomography (CT Scan)

viii. MRI Scan

ix. Mammography

x. Imaging guided procedures, like biopsies and drainage.

* Need discussion before appointment can be given. (For examinations that are not listed above or below, in section 4.3, please enquire from radiologist.)

xi. Mobile Services
- General Radiography
- Ultrasonography
- C-Arm Image Intensifier

b. Provision of services during normal office hours, with emergency service extended to outside office hours.

c. **Services not available** (referred to other Units or Hospitals)

Type of Investigation	**Hospitals/Units**
1. Angiography	SGH, Kuching
2. Cardiac Echocardiography	Physician or Paediatrician, Sibu Hospital.
3. ERCP	SGH, Kuching.
4. MSCT	SGH, Kuching.
5. Radioisotope scans	SGH. Kuching
6. PET CT	Putrajaya Hospital
7. Bone Densitometry	SGH, Kuching

d. Contingency Plan for Equipment Failure

i. In case of equipment failure, the Radiology department personnel shall arrange for an urgent examination to be done by the third party as per Master Agreed Plan and HSIP. Arrangement for transport of patient shall be done by requesting clinician. Non urgent case may be rescheduled.

ii. For an examination that is sent to the third party, the retrieval of film and report shall be the responsibility of requesting clinician

11.3.3 **Diagnostic Imaging Examination Related Policies / Policies Related To Components Of Service**

a. Requesting For Diagnostic Imaging

i. A request form, PER SS-RA 301 or TPC Imaging order must be submitted, the former completed in duplicates.
   - Incomplete form shall be returned.
   - There shall be adequate clinical data to justify the request.
   - The requesting doctor is to print his / her name below his/her signature if he/she does not have a chop.

ii. A request shall be made by a registered medical doctor in the government service.

iii. A request for special examination signed by medical officer must be countersigned by a specialist to show that it is made with consultation to the specialist in charge. However, when the clinical data is clear, the request may be accepted without specialist's signature.

iv. Doctors in other MOH hospitals referring patients for urgent imaging procedures need to coordinate with their appropriate counterpart in the referral hospital for the necessary arrangement.

v. A request for certain examination shall be accompanied by a fully completed consent form. The examinations are:
   - Examinations that are invasive, e.g. myelogram; MCU;Barium Enema for intussusceptions; etc
   - Examinations that require intravenous contrast media :IVU; CT Scan; MRI ;etc.

vi. An IVU and CT Scan request shall have blood urea or serum creatanine result stated on the form or evidence that the result shall be available before the IVU is due e.g. blood had been sent.

vii. An MRI examination request shall have blood urea and serum creatanine result stated on the form

b. Scheduling of Special Examination and preparation of patient

i. An appointment for a special examination shall be given upon receipt of a fully completed form. However, the polyclinics and the district hospitals shall be given the appointment through phone for an out-patient and fax for an in-patient.

ii. When an appointment is made, the patient shall receive an appointment sheet stating the date and time of the examination and the instruction for preparation for the examination. The referring doctor (or his/her assistant) is to explain the preparation to the patient if the patient does not collect the appointment sheet personally.

iii. A patient for an emergency CT Scan must be registered in Accident and Emergency Unit first and be stabilized there, if necessary, before sending to Radiology Department.

c. Registration of Examination

i. All examinations shall be registered into BukuPendaftaran (PER-SS-RA-101 Pins. 1/2003) and into the TPC system. This includes examinations done on hospital staff, family members or friends of department's personnel.

d. Diagnostic Imaging Service After Office Hours

i. Limited number of personnel are available at lunch break and after office hours. The radiographer on duty shall attend only to urgent cases. All non-urgent requests shall be attended during office hours when there is more staff available.

e. Mobile Radiography

i. Mobile radiography shall only be performed in the wards and Accident and Emergency Department for a patient who is not suitable to be transferred to the X-ray Department for radiography.

ii. For Accident and Emergency Department, urgent request for mobile radiography, can be made through phone. The phone request slip shall be filled and attached to the X-Ray request form.

f. X-Ray In Operation Theatre

The request form for the intra-operation X-ray must be sent to the X-ray Department at **least one day** earlier so that staff can be made available.

g. Radiography Of Dead Body

i. This examination shall be done during office hours except during long weekends or public holidays. They are done as mobile radiography in the mortuary.

ii. This x-ray should not be done in the following situations:-

- When the cause of death is obvious e.g. smashed head
- X-ray of body parts where the injury is obvious e.g. clinically obvious fractures or amputated limbs.
- When post-mortem is going to be done. (Unless requested by the Pathologist (e.g. to locate bullet).

- When X-ray does not help to establish the cause of death e.g. suspected pulmonary embolism, intra-abdominal injury, myocardial infarct.

h. Patient's care During Imaging Study and Procedure

i. The ward trained staff/doctor are occasionally required to accompany the patient to the Unit.

- To escort unstable patient who needs special attention.
- To give sedation to paediatric and/or restless patient. Intravenous sedative is to be brought along by attending medical officer from the ward.
- To perform or assist procedures (e.g. liver abscess drainage, assist in barium enema examination for intussusception reduction or hysterosalphingogram).
- To give intravenous contrast media when necessary
- To resuscitate patient with allergic reaction or complications during procedures (e.g. Anaphylactoid reaction; Bronchospasm; haemorrhage, cardiac arrest etc)

ii. If the patient sedation is inadequate, and the procedure cannot be carried out. The patient shall be rescheduled and referred to anesthetist for GA. Paediatric cases requiring sedation shall be admitted.

iii. For an emergency in the department, the Radiology Department personnel shall initiate resuscitation and initial management. Crash team will be called (extension 2112) when necessary. Thereafter, an in-patient shall be sent to the respective ward and out-patient shall be sent to A & E Department.

iv. For death occurring in the Radiology Department, the cause of death shall be determined by the referring clinician. The deceased body shall be sent to the ward in the case of in-patient and to A& E in the case of out-patient

i. Reporting of imaging examinations

i. The request shall be made by submitting the carbon copy of the original request form, with updated clinical data, together with the x-ray film(s).

ii. An incomplete request form or form with inadequate clinical data shall be returned

iii. As far as possible, a special examination shall be reported before dispatch.

iv. All special examinations shall eventually be reported. A general examination shall be reported on request only.

v. A duplicate copy of the report shall be filed in the Radiology Department.

vi. An examination done in private or other hospitals(where it had been reported) shall not be re-reported but only a verbal opinion shall be given

j. Handling of X-Ray Films

As far as possible:-

- An x-ray film shall not be rolled or folded.
- There shall be no marking or drawing on the films.
- The x-ray films for in-patients shall be collected from the unit to ward by the ward staff
- An x-ray film must not be given to a patient without prior approval from the unit
- A patient may be allowed to take his film(s) for second opinion by following a standard procedure. He shall make a request through his clinic/ward doctor at the reception counter and sign his name in the record book.
- The ward/clinic staff shall inform the unit whenever a patient is being referred or transferred to another hospital.

k. Tracing of Old Films

Old films shall only be traced from the Unit by using an appropriate form (Tracing Request Note)

11.4 INTENSIVE CARE POLICY

11.4.2 The unit shall operate as a multidisciplinary general ICU.

11.4.3 The ICU consists of 14 beds with 2 isolation rooms.

11.4.4 The unit shall not segregate patients by class or gender.

11.4.5 **Admission**

a. The intensivist/anaesthesiologist will be responsible for patients admitted to ICU. The anaesthesia team will be in charge of all patients except those admitted by the paediatric team.

b. No patient shall be admitted to the ICU without prior consultation with the intensivist/anaesthesiologist in charge.

c. Paediatric team is encouraged to discuss admission of paediatric cases to ICU with the intensivist/anaesthesiologist in charge regardless of the number of available beds to avoid confusion.

d. All patients shall be admitted via the emergency room, admission room, operating theatre or wards.

e. All resuscitation of medical or surgical emergencies shall be started in respective wards prior transfer to ICU. Haemodynamic stability of patients

prior to transfer shall be informed to Anaesthesia Medical Officer/ Anaesthesiologist prior to transfer. This is to prevent avoidable deaths on arrival to ICU.

f. The ICU is a valuable resource and should be reserved for patients with reversible medical condition and a reasonable prospect of substantial recovery. Exceptions are based on clinician and intensivist's/anaesthesiologist's discretion.

g. Admission criteria (Management Protocols in ICU, Ministry of Health 2012)

11.4.6 **Respiratory**

a. Acute respiratory failure requiring ventilatory support
b. Acute pulmonary embolism with haemodynamic instability
c. Massive haemoptysis
d. Upper airway obstruction

11.4.7 **Cardiovascular**

a. Shock states
b. Life threatening dysrhythmias
c. Dissecting aortic aneurysms
d. Hypertensive emergencies
e. Need for continuous invasive monitoring of cardiovascular systems

11.4.8 **Neurological**

a. Severe head trauma
b. Acute spinal cord injury
c. Status epilepticus
d. Meningitis with altered mental states and respiratory compromise
e. Acutely altered sensorium with potential of airway compromise
f. Progressive neuromuscular dysfunction requiring respiratory support and/or cardiovascular monitoring
g. Brain dead or potentially brain dead patients who are being aggressively managed while waiting organ donation status

11.4.9 **Renal**

a. Requirement for acute renal replacement therapy in an unstable patient
b. Acute rhabdomyolysis with renal insufficiency

11.4.10**Endocrine**

a. Diabetic ketoacidosis complicated by haemodynamic instability and altered mental status
b. Hyperosmolar hyperglycaemic state
c. Thyroid storm or myxoedema coma with haemodynamic instability
d. Hyperosmolar state with coma and/or haemodynamic instability
e. Adrenal crisis with haemodynamic instability
f. Other severe electrolyte abnormalities

11.4.11**Gastrointestinal**

a. Life threatening gastrointestinal bleeding
b. Acute hepatic failure leading to coma, haemodynamic instability
c. Severe acute pancreatitis

11.4.12**Haematology**

a. Severe coagulopathy and/ or bleeding diathesis
b. Severe anaemia resulting in haemodynamic and/or respiratory compromise
c. Severe complication of sickle cell crisis
d. Haematological malignancy with multi organ failure

11.4.13**Obstetric**

a. Medical conditions complicating pregnancy
b. Severe pregnancy induced hypertension / eclampsia
c. Obstetric haemorrhage
d. Amniotic fluid embolism

11.4.14**Multi system**

a. Severe sepsis or septic shock
b. Multi organ dysfunction syndrome
c. Polytrauma
d. Dengue haemorrhagic fever / dengue shock syndrome
e. Drug overdose, poisoning and adverse drug reaction with potential acute decompensation of major organ system
f. Environmental injuries
g. Severe burns

11.4.15**Surgical**

a. High risk patients in the peri operative period
b. Post operative patients requiring continuous haemodynamic monitoring/ ventilator support

11.4.16**Patient Management**

a. All admission shall be attended to immediately by the anaesthesiaMO or paediatric MO and the respective discipline MO.

b. The anaesthesia team shall fully manage the patients admitted to ICU with input from the primary team (except cases admitted by paediatrician).

c. Primary teams should review their patients in ICU at least once a day or more frequently when needs arise.

d. All orders to be written by the ICU team. All orders written by other units must be discussed and agreed upon by the ICU team member prior to initiation

e. There will be only one set of case note for each patient and shall be a continuation form the patient's ward case notes. The case note shall be chronological documentation of the patient's progress as documented by doctors from the various units. All clinical and nursing notes, management and

treatment ordered for the patient shall be written legibly, signed and name stamped.

f. Consultation from other units will be sought when need arises.

g. To reduce traffic in ICU, the number of visiting doctors shall be restricted.

h. Drugs prescribed to patients shall be in accordance to the approved list of drugs of the Ministry of Health.

i. The ICU shall admit patients of all ages.

j. An emergency trolley shall be made available at all times. The contents of the trolley shall be checked every shift and replenished accordingly.

11.4.17**Discharge**

11.4.17.1 Discharge criteria

a. Priority 1: Patients are discharged when their need of intensive treatment is no longer present.

b. Priority 2: Patients are discharged when intensive monitoring has not resulted in a need of intensivetreatment and the need of intensive monitoring is no longer present.

c. Priority 3: patients are discharged when the need for intensive treatment is no longer present but may be discharged earlier if continued treatment is futile or request for ICU bed for a priority 1 and/or 2 patient is made.

11.4.17.2 The intensivist/anaesthesiologist shall be responsible for discharging patients from ICU.

11.4.17.3 A discharge summary will be written by the anaesthesia MO upon discharge from ICU.

11.4.17.4 The primary unit shall be informed of any discharge. The primary unit should then make arrangements for the appropriate ward or intermediate care and promptly transfer the patient out of ICU.

11.4.17.5 The admission room shall be informed of inter ward transfer and discharges, including deaths of patients.

11.4.17.6 Patient movement

a. Patients shall be transported on mobile beds, wheel chair or trolley.

b. The nursing staff and ward attendant shall be responsible for moving the patient within the department as well as other department if patients are not for discharge yet, accompanied by a doctor (e.g. imaging studies).

c. The nursing staff and ward attendant of respective wards are responsible for moving patients to and from a ward upon admission to or discharge from ICU. All admission shall be accompanied by a doctor.

d. Transfers in between hospitals will be arranged and escorted by the primary team with advice from the anaesthesia team regarding patient safety and stability.

e. Any patient who died in the hospital shall be transported on a cadaver trolley to the mortuary by a mortuary attendant

11.4.17.7 Documentation

a. All treatment ordered shall be documented in the patient's case note.
b. ICU shall maintain a record for all patients.
c. A daily census of all patients shall be carried out.
d. The ward shall maintain a record and notify the hospital director of any untoward incidence occurring in the ward.

11.4.17.8 Any case under police custody shall be guarded by the police unless permitted by the police otherwise.

11.4.17.9 Talking to patient's relatives.

a. Only doctors shall inform the patient's condition and prognosis to his/her next of kin.

b. The next of kin of dangerously ill patients shall be informed immediately. If they are not available, the message could be conveyed by telephone or radio message.

c. The patient's next of kin wishing to bring the patient to leave the hospital against medical advice may do so in writing by using the appropriate form.

d. The next of kin shall be informed of patient's death in the ward. If they are not available, they may be notified by phone or radio message service if necessary. The cadaver shall be sent to the mortuary at the end of an hour for release to next of kin or for postmortem examination.

e. In the presence of medico legal issues or the like, explanation should be made by the intensivist/anaesthesiologist/primary team specialist in charge of the patient, or senior medical officer in the absence of intensivist/anaesthesiologist.

11.4.17.10 Medical Certificate of the Cause of Death shall be signed by the primary team.

11.4.17.11 No leave of absence shall be granted to the patients.

11.4.17.12 All notifiable disease shall be notified to the health office within 24 hours.

11.4.17.13 Consent shall be obtained from the patient or next of kin prior to

carrying out any procedure. In case of an emergency and after all effort to trace relatives and next of kin have failed, the hospital director and specialist shall authorize for the procedure to be carried out.

11.4.17.14 Cases requiring surgery in the operating theatre shall abide by the policy of the operating theatre.

11.4.17.15 All referrals shall be made in accordance to the existingguidelines as stated in the 'GarisPanduanRujukan'.

11.4.17.16 Isolation rooms in ICU shall be used for isolation or reverse isolation nursing care.

11.4.17.17 Mosquito nets shall be provided for dengue and malaria cases.

11.4.17.18 Visiting hours

a. The visiting hours shall be limited to twice a day. Only 2 visitors are allowed for a patient at a time except in certain circumstances.

b. No visitor shall be allowed to stay with the patient. The relatives are allowed to see the critically ill patient at any time with the approval from the doctors, nursing sister, or staff nurse in charge. However, they are encouraged to follow the hospital visiting hours.

c. All visitors must leave the ICU whenever it is necessary for any medical care to be rendered.

d. Children under 12 years of age may only visit with the permission of the ICU doctor.

11.4.17.19 The patients shall be charged according to the Fees (Medical) Order Act 1983.

11.4.17.20 In the event of a new case being admitted when the ICU beds are fully occupied the intensivist/anaesthesiologist may transfer a patient with a poor prognosis to the general ward. The ventilator support shall be continued with a ward ventilator. The anaesthesia team shall continue to look after the ventilator care of the patient in the general ward.

11.4.17.21 Ventilation in General Ward

a. Ventilation will be managed by anaesthesia team. Settings will be reviewed by anaesthesia MO or intensivist/anaesthesiologist daily.

b. Ward nurses will be trained to care for ventilated patients either through ICU attachments or practical ventilator care course.

c. Anaesthesia MO on call shall attend to any ventilator related problem as soon as possible.

11.4.17.22 All female patients examined by a male medical staff shall be chaperoned by a female staff.

11.4.17.23 All coronary patients shall be orientated on the facilities available in the ward. The patients shall be made aware of the regulation of the hospital e.g. no smoking, visiting hours etc.

11.5 **OPERATING THEATRE POLICY**

11.5.2 **Usage of Operation Theatre**

a. There are 8 operating theatres within the Main Operating Suite and 2 operating theatres in the Maternity Operating Suite. These operating theatres are for surgery requiring the use of either local or general anaesthesia. Currently, the 2 operating theatres in the Maternity Operating Suite are used by the O & G unit for Colposcopy procedures on every first and third Monday of every month and emergency LSCS.

b. These operation theatres are opened for elective cases as scheduled with 1 operation theatres standby for emergency cases.

c. Departments involved in the usage of the operating theatres are General Surgery, Neurosurgery, Obstetrics &Gynaecology, Orthopaedics, ENT, Ophthalmology and Dental.

d. Visiting specialties i.e. Urology, Pediatric Surgery, Plastic Surgery and Oral Surgery have regular surgeries scheduled on a rotational basis. Neurosurgery and Spine Surgery occasionally carry out surgeries during their visits.

e. Some diagnostic procedures are done as Day Care procedures. These are mainly endoscopic procedures such as OGDS, Bronchoscopy, Colonoscopy, Sigmoidoscopy, FNPLS and Cystoscopy. These are performed in the major Operating Suites.

f. OT service is available 8.00am - 4.00pm on working days for elective cases; and 24 hours i.e. 8:00am to 8:00am the day after during both working days and non-working days for emergency cases.

11.5.3 **Elective cases**

a. Elective major and minor surgeries or procedures are generally scheduled to be done from 8:00am - 4:00pm continuously on working days.

b. The elective OT list is prepared by the individual user department. It should be submitted to the OT before 12 noon on the day prior to the planned surgery or procedure, so that it could be screened by the Anaesthesia Team a day before the planned surgery or procedure. Any changes to the elective OT list must be notified to the OT staff before 5:00pmon the day prior to the planned surgery or procedure.

c. Priority on the list shall be given to pediatric and diabetic patients while clean cases shall be done preferably before infected or dirty cases.

d. Anticipated long cases should be scheduled early to avoid overtime.

e. Anaesthesia Medical Officer is to do preoperative assessment on patient for elective surgery a day before the planned surgery or procedure. Preoperative assessment, premedication, anaesthetic plan and patient's consent for surgery and anaesthesia must be documented properly in the Anesthetic form (PER-ANAES-301). Patients who are admitted later than 4:30pm will be assessed in OT on the day of surgery as if it is a semi-emergency surgery. If the patient is deemed not fit for the surgery, the surgery will be cancelled.

f. Patient with multiple, complicated medical illness is advised to be admitted earlier so that they could be referred to the Anaesthetist earlier for assessment, referral to other disciplines if necessary and treatment in order to optimize their medical condition prior to the planned surgery or procedure.

g. Anaesthesia either general anaesthesia, regional anaesthesia or combined anaesthesia is administered by the Anaesthetic MO and Anaesthetic Assistant Medical Officer under the supervision of the Anaesthetist (according to the protocol for general and spinal anaesthesia).

h. The first patients should be prepared and ready in OT, all parties involved ready (anesthetic preparation, nursing preparation and surgeon) so that surgery for the day may start at 8:00am. This will maximize OT usage and avoid problem with inadequate OT time.

i. On operating day, the surgeons are advised to adhere to the order of the list as far as possible.

j. Cases shall not be cancelled unnecessarily on the day of operation. In the event of cases being cancelled when patient is already in the OT, the Anaesthetic MO and the MO of the primary team in-charge of the patient shall inform the patient of the reason for cancellation.

11.5.4 **Emergency Cases**

a. Any emergency case has to be notified by filling in properly the emergency case OT chit and submit to OT. If the case is deemed very urgent, it may be conveyed to the Anesthetic MO on-call so that timely arrangement may be made to shorten waiting time.

b. Emergency cases shall be informed to the Anesthetic MO on-call, for timely arrangement of cases to prevent unnecessary prolonged fasting, and to allow assessment and resuscitation of patients prior to surgery if necessary.

c. The patient for emergency surgery will be assessed by the Anesthetic MO on-call either in their respective wards or in OT.

d. Patient for emergency surgery will be called at soonest available time, in between elective cases or at other time depending on the urgency, the nature of the surgery and the staff capacity.

e. Anaesthesia either general anaesthesia or regional anaesthesia is administered by the Anaesthetic MO on-call and Anaesthetic Assistant Medical Officer on-call under the supervision of the Anaesthetist on-call. (according to the protocol for general and spinal anaesthesia).

f. Dire emergencies may be transferred to the Operation Theatre straight from the Emergency & Trauma Unit after resuscitation and stabilization had been established. These patients shall be transferred to the unit wards or ICU after the operation.

11.5.5 **Receiving and discharging patient**

a. The staff nurse in-charge i.e. reception nurse will ring the ward concerned to call for the patients scheduled for the day one by one for each OT.

b. Patient is brought to the Operating Suite by the ward nurse and attendant and handed over to the OT nurse at the transfer bay. The OT nurse will receive the patient according to standard procedures using the peri-operative checklist.

c. Post-operatively, the patient is observed and cared for in the recovery bay. Before discharging the patient, patient is assessed by the anaesthetic personnel. All patients should have adequately recovered and in stable condition before discharged by the Anaesthetist, Anaesthetic MO or Anaesthetic Assistant Medical Officer.

d. After certified fit for discharged, the patient will be checked before being transferred out of OT according to standard procedures.

11.5.6 **Discipline and behavior in Operation suite**

a. All staff, patients and visitors shall abide by the rules and regulations of the operating theatres.

b. Talking and noises are to be minimized inside OT proper while any operation or procedure is going on.

c. Magazines/catalogues or storybooks should be minimized in OT proper except Medical books meant for referral or students' log books.

d. No food or drinks shall be brought into the OR and should only be consumed inside the allocated pantries.

11.5.7 **Protective Clothing for Use in the Operating Theatre**

a. All OT users and personnel shall change into approved OT attires upon entering OT suite.

b. No street clothes shall be worn within OT suite or inside OT attires. Should the staff or any OT users need to use extra clothing, fresh and new clothes shall be used instead.

c. All OT personnel or staff shall change into the standard OT slippers and boots which should fully cover the feet upon entering the OT suite. Street shoes shall be removed at the OT staff entrance.

d. Mother or guardian of paediatric patients are encouraged to accompany patient up to the process of induction in the operating theatre. Paediatric patients shall not be required to change into OT gowns but clothes used should be clean.

e. No OT attires shall be worn outside OT unless to attend to medical emergencies outside. but if done so, the personnel concerned have to change into fresh OT attires before re-entering the OT suite.

f. Masks are to be worn when entering the Operation Room. A single disposable 3-ply surgical mask which is 95%efficient in filtering microbes from droplet particles in exhalation and also filter inhalation. Fluid resistant mask is an advantage. Masks are to cover the nose and mouth and to be tied securely to prevent venting at the sides properly. Change mask when necessary; when wet / soiled or after it has been removed for other purposes.

g. Cap is worn to protect gross contamination from hair during procedures. The cap worn should not be less than 40 grams of weight. All hairs are to be tucked neatly under the theatre caps.

h. Staff are to use slippers meant for toilet when entering the toilet.

i. Used OT attires are to be placed in the laundry bags provided and used caps and masks are to be placed inside the pails provided.

11.5.8 **Infection Control and cleanliness**

a. Policies and procedures pertaining to the infection control practices within the Operating Suite as stipulated inside the Policies and Procedures on Infection Control (2010) and the Disinfection and Sterilization Practice, Ministry of Health shall be observed.
b. Strict adherence to the guideline on Universal Precaution and Standard Precaution is mandatory.
c. Environmental surveillance by air sampling shall be done by the Hospital Infection Control Unit after every major closure of the OR for any renovation, upgrading, repair or suspected contaminations by infectious diseases.

d. Doors of all the OR shall be kept closed at all times to maintain the OR positive pressure. Air exchange per hour shall be maintained between 15 to 25 exchanges per hour.

e. The temperature within all the OR shall be in the range of 18^0 C to 22^0 C and with a humidity range of 50% to 60% to minimize surgical site infections and electrical burns.

f. All staff and OT users shall adhere to aseptic techniques throughout the operations and procedure by: -
   - practicing correct surgical hand scrub before every surgery
   - donning face mask and shield, sterile gowns and sterile gloves

11.5.9 **Specific Standards for Operating Theatre**

a. Environmental Requirements
   Apart from provision of safe water, uninterrupted power supply, provision of stable temperature and humidity, the main requirements are:
   - A controlled Filtered Air to provide fresh air and prevent accumulation of anaesthetic gases in the operating room.
   - Active scavenging system for anaesthetic gases

11.5.10**Safety in Operating Suite**

a. All staff and OT users shall adhere to the Safe Surgery, Saves Lives protocols by completing each checklist designed inside the SSSL form.

b. All staff shall adhere to the Standard Operating Procedures of administering drugs and recording of Dangerous Drugs being used.

c. All machines and equipments used shall be checked for their functioning order before use and periodic maintenance by the HSS shall be done according to schedule. Any non functioning machines or equipments shall be reported and repaired by qualified HSS technicians. Details of diathermy application and usage refer to standard protocol. (Refer to Operation Theatre work procedure file)

d. Compressed Gas cylinders must be handled carefully according to standard

e. The image intensifier shall be handled by trained x – ray personnels and privileged OT staff only. Staff and OT user performing surgery or procedures requiring image intensifier shall use lead gowns for protection.

11.5.11**Loaner Instruments**

a. Any request by private medical centers shall be approved by the Hospital Director and instruments shall be cleaned, disinfected and in good functioning order upon returned to the Hospital.

b. Instruments on loan from private medical centers or companies shall be required to be free from any contaminants, supplied with items inventory list and handed over to the CSSU staff by the OT staff accordingly.

c. After being used, the hospital CSSU shall clean and decontaminate the used instruments but shall not be obliged to sterilize the instruments.

11.6 PATHOLOGY DEPARTMENT

11.6.2 Operational Policies

a. General

- Requesting Lab tests
  ONLY the Specialists/Medical Officers/House Officers could make request for laboratory tests. In order to provide a cost effective, efficient and rapid service, clinicians are urged to be more selective in requesting laboratory tests especially non-routine tests.

  (a) only PER-PAT 301 or other designated forms as well as correct specimen container shall be used

  (b) a written confirmation (completed laboratory request form) is needed following any verbal requests

  (c) Full identification of the patient is required i.e. full name, registration number (or identification card number), age, sex and location of ward clearly stated

  (d) name, signature and date of the attending Medical Officer

  (e) Legible and clear written order for the tests requested

  (f) relevant medical history, diagnosis and medications or treatment must be included in the request forms (e.g. for Dengue Blot Test, date of onset and date of specimen taken must be included); and

  (g) Clear labelling of the specimens with tests, name of patient, identify card number and ward stated, identification of the nature of the specimen as well as precautionary handling where applicable.

b. Patients from Specialist Clinics

The patients from Specialist Clinics shall present themselves at the Clinical Laboratory to provide the necessary samples or specimens.

- Specimens collection

Specimens collection & venepunctures shall be carried out at the reception counter of Clinical Laboratory by privileged MLT (JTMP U29) or qualified Assistant MLT (JTMP U14).

c. In-patients

In-patients shall have their specimens taken in the wards and sent to the laboratory by the Portering Service or ward staff. However, a JTMP shall go to the ward for Bone Marrow Smear, Bleeding Time, Clotting Time examinations according to appointment system.

d. Laboratory results

- All laboratory results shall be made available for collection by respectively ward or clinic staff at the Dispatch Counter in Chemical Pathology Laboratory. The laboratory results should be collected at least twice a day.
- A laboratory results may be released over the telephone when requested, and notification of critical laboratory result will be done through telephone. The request shall be recorded in Telephone Call Log Book. The laboratory shall not be held responsible for any misconstrue that occurred as a result of the telephone notification. Hence, following the call, the requesting units are responsible to collect the hard copy of the result as soon as possible.

e. Special test

- In the event a special test (e.g. frozen section) is required, the specialists should liaise with the pathologist (if available) a few days earlier so that an appointment could be arranged. (Please refer to Hospital Sibu Laboratory User Manual).

f. Specimen containers

- The specimen containers with/without special preservatives can be obtained from the Preparation Room in the Bacteriology Unit (54E) of Pathology Department, Sibu Hospital.

g. **Hospital Sibu Laboratory User Manual**

- All specimens must be collected and sent to the Laboratory in accordance with the Hospital Sibu Laboratory User Manual.

h. **Urgent test**

- Urgent tests request must be attached with the TAT form.

i. **Non-essential tests requested after office hours**.

- Non-essential tests requested during weekends, public holidays or after office hours will not be processed until the next working day. Non-routine test e.g. fasting lipid profile, hormonal assays (T4, TSH) etc. are performed in batches.

j. Medico-legal specimens

- All medico-legal specimens must be collected in the presence of the designated officer. The specimen(s) is subsequently sealed and sent to the laboratory by the designated officer to maintain the chain of custody.

k. Review of request form and specimen

- Request form and specimen will be reviewed in the laboratory to ensure that they conformed to specification. Request for test will be rejected if:

  a) The test requested is not offered by this laboratory or other designated referral laboratory (e.g. CEA, CA 125 etc.)
  b) Wrong request form is being used
  c) Name of attending medical officer, signature and test requested is not written in the form
  d) Name of patient and complete identification not filled up
  e) Destination of ward is not stated
  f) Request form is not accompanied with specimen (no specimen received) or specimen is received by lab without request form
  g) Information about patient's identification labelled on the specimen container does not match with the identification written on the request form
  h) Container for specimen is not labelled with complete patient's identification
  i) Wrong specimen container is being used
  j) Broken, leaking or empty specimen container received
  k) Insufficient volume of specimen for the test requested
  l) Grossly haemolysed specimen
  m) Request forms or specimens not meeting requirements

  If the request forms or specimens do not meet the laboratory requirements, a rejection form, together with the request form, will be issued to the requesting units. Specimen(s) for the rejected request shall be retained in the laboratory until new request form which has been duly filled or fresh specimen(s) is submitted or at a period of time deem appropriate by the respective units and be disposed safely thereafter. A record on test rejection shall be maintained by each laboratory unit.

l. All tests shall be carried out according to validated procedures

All tests shall be carried out according to a validated procedure to ensure accuracy of their reports. Whenever applicable, all tests shall be carried out only after acceptable internal Quality Control values are obtained and the calibration is done.

m. Remaining specimens

All remaining specimens after the completion of tests shall be retained for a period of time deem appropriate by the respective units and disposed safely thereafter.

n. Record of test results

All test results must be recorded in their respective record book before dispatching to their requesting units.

o. Specimens forwarded to referral institutes

- All specimen sending to referral laboratory will be monitored by respective unit according to TAT of the test as committed by the referral or external laboratory or determined by our own laboratory in the event where no standard TAT is given for the tests.

- Specimens forwarded to referral institutes must be recorded. The test results should be recorded or kept a copy for reference.

- Laboratory should trace the results as according to the LTAT of external government laboratory.

- For government owned external laboratory, the original copy of all specimen results must be sent to the laboratory for compilation and the laboratory shall dispatch a photostated copy of the result to the respective units

p. Specimen sent to private laboratory

Laboratory shall have an MOU with private laboratory for tests not provided by the government laboratory or tests which are not locally available. The results of the tests shall be sent directly to the requesting unit and a copy to the laboratory.

q. Laboratory tests charges

The laboratory tests shall be charged in accordance to the Fees (Medical) Order, 1982. The fees coding must be written on the request forms together with the date of test, name and signature of the performing laboratory personnel.

11.7 Blood Banking Service

11.7.1 A register of blood donors shall be maintained.

11.7.2 All blood donors shall be examined and the consent form must be completed before his/her blood is taken. The bleeding shall be conducted by qualified JTMP.

11.7.3 The privileged leaves for blood donors can be issued by Medical Officer or the Blood Bank JTMP U36/U32.

11.7.4 All blood shall be stored accordingly and screened for HIV, Hepatitis B, Hepatitis C, VDRL and malaria parasite. Hospital Sibu is the screening centre for blood safety for Central Zone of Sarawak (Kapit, Mukah, Sarekei, Daro, Kanowit, Dalat, Betong and Saratok), using EIA Method monitored by National Blood Transfusion.

11.7.5 Unscreened blood or blood components shall be stored separately from screened blood.

11.7.6 The required internal QC and external QC should be done accordingly.

11.7.7 Only screened blood and blood components which are non-reactive in all screening tests for all defined markers shall be released for transfusions.

11.7.8 All reactive units should be removed from a quarantined stock and stored separately and securely until they are disposed of safely.

11.7.9 Confirmatory testing of reactive donations should be undertaken for donor notification, counselling and referral for treatment, deferral or recall for future donation, and look-back on previous donations.

11.7.10 Medical Officer is responsible in the management of seroconvert donors and seroconvert recipients by following the Quality Procedure HS/BTS/QP-03. Reactive donors from district hospital should be followed up by their medical officer.

11.7.11 Systems should be put in place to maintain the confidentiality of test results.

11.7.12 Records should be kept to ensure traceability of blood to donors.

11.7.13 The Blood Bank shall ensure that sufficient units of blood are available at all times and appropriate actions should be taken when the blood level reaches yellow alert level.

11.7.14 No blood or blood components shall be stored beyond the recommended time period (7 days for platelet concentrates, 42 days for packed cells, or 1 year for fresh frozen plasma or cryoprecipitates)

11.7.15 Any blood and blood products shall be stored under the recommended temperature under the national standard guidelines and in the event found breaching the requirement, it shall be safely discarded.

11.7.16 Blood/blood products shall only be issued from the Blood Bank on receipt of the blood request forms which has been duly filled and signed by a Medical Officer.

11.7.17 Telephone requests for blood products should be made by a medical officer or during difficult circumstances by a delegated individual. Laboratory personnel receiving verbal requests will record name of requestor and received a written confirmation (completed laboratory request form) from requestor prior to issuing of blood or blood products.

11.7.18 The units of blood/blood products shall be issued or used on a "first in first out" basis according to blood groups.

11.7.19 The person authorized to collect the blood are Staff Nurse, Medical Assistant, Houseman, Medical Officer, and Specialist.

11.7.20 Blood bank personnel must check the patient particulars match with those labelled at the blood unit to be collected and record the date and time of issue and collection.

11.7.21 Both the staff who issued and collect the blood/blood products must initial in the record book.

11.7.22 Blood & blood products should maintain storage temperature between 2°C -8°C during transportation and prior to transfusion for patients.

11.7.23 Blood and blood product must be kept at the appropriate temperature in blood fridge and freezers and returned to the blood bank within 24 hours if not used.

11.7.24 Consent of patients need to be taken prior to blood transfusion by Medical Officer/Houseman/Specialist.

11.7.25 Blood and blood products must be checked by Medical Officer/Houseman together with the staff nurse in compliance with the standard procedure prior to transfusion as to prevent any transfusion error.

11.7.26 All blood/blood product transfusion practices must comply with standard precaution.

11.7.27 Blood discontinued for any reason must not be used again and must be labelled as "USED BLOOD" and returned to the Blood Bank.

11.7.28 Blood bank staff should ensure that the Recipient Card attached to each used bag of blood component is filled completely after completion of transfusion and return to the blood bank.

11.7.29 If a transfusion reaction occurs, the ward must inform the Blood Bank staff immediately, so that the transfusion reaction investigation could be initiated early.

11.7.30 Supply of blood to private hospital must comply with the agreement between the hospital and private hospital. Any complication of the patient in the private hospital due to blood transfusion is in the responsibilities of the private hospital.

11.7.31 Fee charged to private hospital is according to the current price of consumable item. It is charged under barter system whereby private hospital will pay back in the form of reagent or consumable item.

11.7.32 All blood products sent to private hospital are not returnable.

11.7.33 The Blood Transfusion Committee at hospital level should meet at least twice per year to oversee the Blood Banking Service.

11.8 Forensic Service

a. Forensic procedures.
   All forensic procedures should be carried out by forensic pathologist or assigned competent medical officers

b. Histopathology examination.
   All biological specimens with diagnostic potential should be sent for histopathology examination.

   The cost of outsourced specimen deemed necessary by the specialist shall be borne by hospital.

11.9 PHARMACY SERVICE

11.9.1 Prescription and supply of drugs not listed in the Hospital drug formulary but available in the Ministry drug formulary (blue book) shall require the respective specialist or head of department's approval.

11.9.2 Prescription and supply of drugs not listed in the Ministry drug formulary (blue book) shall require the Ministry's approval. The respective head of the department shall be responsible for justifications of drug usage and cost implication. Request for approval shall be made using specified format and submitted through the director's office.

11.9.3 Doctors shall prescribe drugs only to registered patients.

11.9.4 Prescription referred by the Pharmacy Department from other Ministry of Health hospitals and clinics shall be accepted.

11.9.5 Prescription from the private sector shall not be accepted.

11.9.6 Drug counselling shall be provided to individual patients based on needs.

11.9.7 Bedside dispensing shall be carried out for discharged patients.

11.9.8 Urgent needs after office hours for inpatients shall be met by the pharmacy personnel on call.

11.9.9 All cytotoxic drug prescribing, dispensing and serving should comply to the "procedures on handling of cytotoxic drug".

11.9.10 Usage of drugs, prescriptions and drug reaction shall be monitored by the pharmacy department.

11.9.11 Drug committee shall meet at least twice per year to coordinate, monitor and manage all issues relating to drugs and drug usage. Refer to: (i) *SPKPK Bil.3/1990 Jawatankuasa Ubat-ubatan Negeri/Institusi/Hospital* dated 9 April 1990.

11.9.12 **Supply of Medications**

11.9.12.1 In-patient medications

In-patient medications prescribed during office hours shall be supplied on unit-of-use and floor-stock systems.

11.9.12.2 Additional stock items

The pharmacy is to supply the wards and departments with additional stock items on an indent basis.

11.9.12.3 Emergency medications prescribed after office hours

For Emergency medications prescribed after office hours and not available in ward stock is to be collected from the Pharmacy Department on on-call basis.

11.9.12.4 DD drug cupboard

The DD drug cupboard should be topped-up by the ward via indenting to the in-patients pharmacy on every Tuesday and Friday.

11.9.12.5 Prescriptions for in-patient discharges, specialist clinics and Emergency and Trauma Department during office hours

All prescriptions for in-patient discharges, specialist clinics and Emergency and Trauma Department during office hours are to be dispensed by Pharmacy Department. Prescriptions from Emergency and Trauma Department and in-patient discharges after office hours and up to 10.00 p.m. are to be dispensed by out-patient pharmacy. After 10.00 p.m. prescriptions from and Emergency and Trauma Department are to be dispensed at the Emergency and Trauma Department.

11.10 FOOD SERVICES

11.10.1Food transport

Food is transported in specific food trolleys and plating for second and first class patients is done in the kitchen.

11.10.2All used plates and cutlery are washed in the kitchen.

11.10.3Patient meals

All patients are supplied with 5 main meals a day. Dietary guidelines produced by the Ministry of Health are complied with.

11.10.4On-call Doctors meals

On-call Doctors are to take meals in on-call Doctor dining room only. This room is kept clean at all times as a measure of pest control.

11.10.5Certain staff are provided with food from the kitchen (e.g. doctors on call, staff working through lunch in OT etc.).

11.11 MEDICAL SOCIAL WORK UNIT

11.11.1Referrals

All referrals shall be made by the Medical Officer/ Specialist, using the referral form of the Medical Social Work Unit

11.11.2Name of referring doctor

The name of the referring doctor shall be clearly indicated on the referral form to facilitate case discussion and feedback regarding the referral.

11.11.3Incomplete forms

Incomplete forms shall be rejected and be returned for doctors to complete.

11.11.4Assessment

Social Work Officer shall assess the patient and decide on appropriate follow up referral to other relevant agencies.

11.11.5**Follow-up sessions**

Any follow-up sessions with the Medical Social Work Officer for both inpatients and outpatients, shall be on an appointment basis. The appointment slip will be issued for patients.

11.11.6Out-patient Service

a. The outpatients service receives referrals from:
   - The Specialists Clinics
   - The wards
   - The Polyclinic
   - The Government Hospitals
   - The Accident & Emergency Department

b. Outpatients shall be sent with the referral form and outpatient case card (OPD card) to see Medical Social Work Officer.

c. Any follow-up sessions with the Medical Social Work Officer for outpatients, shall be on an appointment basis. The appointment slip will be issued for patients.

11.11.7In-patient Service

a. In-patient service receives referrals from the ward.

b. Ward staff shall inform the Medical Social Work Officer of any inpatient referral for appointment.

c. The ward staffs shall send the completed referral form and the case note with patient/ relative to see Medical Social Work Officer at the Medical Social Work Officer's office.

d. The Medical Social Work Officer will interview patient in the ward for the special case only.

e. Social intervention, may conducted in the Medical Social Work Officer's office, at the patients home and in the wards if necessary.

f. Any follow-up sessions with the Medical Social Work Officer for outpatients shall be on an appointment basis. The appointment slip will be issued for patients

11.10 **CENTRAL STERILE SUPPLY**

11.10.1 **General**

Sterilization of all instruments and materials that need sterilizing takes place in the Central Sterile Supply Department, apart from the following:

- Sterilization of endoscope is done at OT
- Sterilization of dental equipment
- Sterilization of media, glassware and infected specimens is to take place in the Pathology Department.

11.10.2 The C.S.S.D is to exchange and replace sterile medical instruments and sterile linen from the wards and departments on regular basis.

- All work and materials must follow the specific direction to prevent contamination.

- All returned items shall be treated as potentially infectious or contaminated regardless whether they have been used or not.
- Sterile supplies shall be issued from the sterile issuing area according to schedule.
- Instrument used on Biohazard case must be properly bagged, labeled biohazard and sent to CSSU as soon as possible after informing CSSU staff.

11.10.3 Schedule.

Used C.S.S.U packs from the departments are to be placed in special bags and collected by C.S.S.U staff in the morning (7-8 am). Additional sets on exchange basis can be collected by the ward staff from 2-3 p.m., and emergency sets as per request from 1.00 p.m. to 8.00 p.m. daily and collect at CSSU.

When the CSSU is closed, decontamination is carried out at users place following the guidelines 'Disinfection And Sterilization PolicyAnd Practice'

11.10.4 Commercially sterilized supplies

All commercially packed items should have the outer cover e.g. 'soft good' removed before placing in the vicinity of packing / sterile area.

11.10.5 For high-risk patient, such as known case of HIV/AIDS and Hepatitis B, disposable sets shall be used.

11.10.6 Staff involved in the sterilization process shall follow the standard procedures to ensure the sterility of the product.

11.10.7 Staff shall wear proper attire for safety protection against infection and other hazards.

11.10.8 Sterilization of delicate equipment shall be carried out by trained staff using appropriate technique. Soft dressing shall be pre-packed and sterilized centrally.

11.11. Health Education

i. The hospital shall provide effective health/patient education services in support of inpatient and outpatient care in the hospital.

ii. The Health Education Unit shall plan, coordinate, implement, monitor and evaluate all activities related to health/patient education programs in line with current MOH policies.