


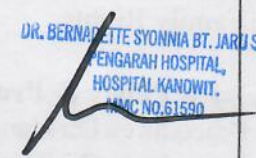
**JABATAN KESIHATAN NEGERI SARAWAK
HOSPITAL KANOWIT**

DOCUMENT: DEPARTMENTAL OPERATIONAL POLICIES & PROCEDURES – NURSING SERVICES	
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DOCUMENT: Departmental Operational Policies & Procedures – Nursing Services

OBJECTIVE: To ensure the nursing care delivered to the patient is effective, efficient and safe in Hospital Kanowit.

SCOPE: All Nursing Staff of Hospital Kanowit

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No.	Contents	Page
1	Objectives	4
2	Scope Of Services	4-5
3	Organisation & Management	5-6
4	Clinical Roles and responsibilities	6
5	Human Resource Development & Management:	
5.1	Human Resource Planning	6
5.2	Orientation	6
5.3	Placement	7-8
5.4	Contingency Plan For Nursing Staff Shortage	8-9
5.4.1	Staff Deployment	9
5.5	Professional Training & Development	9-10
5.6	Credentialing & Privileging	10
6	Operational Policy & Procedures:	
6.1	Nursing Care & Work Process	10-11
6.2	Medical Records Of Patient	11-12
6.3	Management Of Medication & Supplies	12-13
6.4	Discharge Of Patient	13
6.5	Home Leave	13-14
6.6	Transfer Of Patient To Other Wards / Inter-Facility Transfer	14
6.7	Referral of patient to Tertiary Hospital	14
6.8	Death	15
6.9	Patient Safety	15-16
6.10	Patient & Family Rights	16
7	Other Related Policy & Procedures:	
7.1	Policy & Procedures On Care & Management Of Emergency Patient	16
7.2	Policy & Procedures On The Use Of Resuscitation Services	16
7.3	Policy & Procedures On Administration Of Blood & Blood Products	16-17
7.4	Policy and procedure for patient on life support equipment/ comatose patient	17
7.5	Policy & Procedures On Reducing The Risk Of Healthcare Associated Infection In The Hospital	17
7.6	Policy & Procedures For Control & Prevention Of Tuberculosis Among Nursing & Auxiliary Staff	17
7.7	Policy & Procedures For Patient With Communicable Diseases	17
7.8	Policy & Procedures For Management Of Immuno-compromised Patient	17
7.9	Policy & Procedures For Patient On Dialysis	18
7.10	Policy & Procedures For Use Of Physical Restraint On Patient	18-19
7.11	Policy & Procedures On Care Of Vulnerable & Elderly Patient	19
7.12	Policy & Procedures On Patient Receiving Chemotherapy / High Risk	19-20

	Medications	
7.13	Policy & Procedures On Sanitation For Patient	20
7.14	Policy & Procedures On Food & Nutrition For Patient	20-21
7.15	Policy & Procedures Of Treatment For Patient	21-22
7.16	Policy and procedures on prevention of fall among patient in hospital	22
7.17	Policy on patient participation in their care and treatment.	22-23
7.18	Policy on Do not resuscitate	23
7.19	Policy on Informed consent	23
7.20	Policy on end of life care	23
7.21	Policy on Management of patient under police custody	23-24
7.22	Policy on Bed management	24-25
8	Facilities & Equipment	25
9	Safety & Performance Improvement Activities	25-26
App A	Organisation Chart Of Nursing Services	27

DEPARTMENTAL OPERATIONAL POLICIES

NURSING SERVICES HOSPITAL KANOWIT



1 OBJECTIVES

- i. To emphasize the nursing care delivered to the patient is cost-effective, efficient, safe and quality standard
- ii. To provide quality nursing care by the committed nurses who have good knowledge and skills through continuous education and post basic training.
- iii. To adapt the practice of safe care in the safe environment by having the right person to do the right thing at the right time.
- iv. To achieve a high standard in the provision of quality nursing care by applying the core values of nursing, promote health, prevent illness, restore health and to alleviate sufferings.

2 SCOPE OF SERVICES

- i. Primary roles and responsibilities of nursing service is to provide holistic care through teamwork, caring and professionalism. Nurses work collaboratively with other members of the health care team to ensure continuous individualized care.
- ii. Manage the human resource for Nursing staff with regards to their orientation, training, professional registration and deployment.
- iii. Placement of nursing personnel is in the various units / wards which encompass obstetrics & gynecology, medicine , pediatric, surgical, haemodialysis,

emergency, and outpatient nursing services and other support services, that is central sterile supply services, infection control and quality unit.

- iv. Nursing Service provides 24 hours coverage of nursing care by a three shift schedule. On- call Nursing Sisters assigned to standcall every day.
- v. Promoting professional development and continuing education for all nurses..
- vi. Providing and delivering good quality nursing care with high standard of nursing practice and professional conduct.
- vii. Representing the nurses' views and opinions in various issues pertaining to their service and welfare in the various committees of the Hospital.
- viii. Supervise the overall administration and management of nursing accommodation and hostel of the Hospital.
- ix. Monitor and ensure the delivery of high quality linen and laundry services provided by the concession holder.
- x. Monitor and ensure the delivery of high quality cleansing services provided by the concession holder.
- xi. Ensure timely and adequate supply of sterile products and consumables for delivery of patient care activities
- xii. Ensure compliance to disinfection and sterilization policy and procedures of Central Sterile Supply Services.
- xiii. Ensure the provision and delivery of high standard of nursing services to the community both for in-patients and out-patients.
- xiv. Coordinate and assist the Hospital Infection Control Unit to ensure compliance to the policies and procedures in the prevention and control of hospital acquired infection.
- xv. Manage the human resource for Nursing and Auxiliary staff with regards to their orientation, training, professional registration and deployment.

3 ORGANISATION & MANAGEMENT

- i. The Chief Matron assisted by the Nursing Sisters shall manage all aspects of nursing services in the Hospital.
- ii. She shall also be responsible for other services such as CSSS, linen and laundry services, cleanliness within wards, infection control services and quality activities of the Hospital.
- iii. Daily operation of the unit to ensure uninterrupted patient care including:

sufficient supply of linen and drugs, consumables, conducive and safe environment, functioning and safe equipment.

- iv. Planning and resource requisition
- v. The organization of the Nursing Services is shown as in Appendix A.

4. CLINICAL ROLES AND RESPONSIBILITIES

- i. Monitoring of nursing care standards, quality care.
- ii. Nursing documentation (patient assessment/ nursing process/pain management)
 - i. Compliance to policies and procedures by nursing personnel.
 - ii. Clinical nursing audit.
- iii. Enhancing therapeutic nurse-patient relationship
- iv. Patient education and sharing information

5 HUMAN RESOURCE DEVELOPMENT & MANAGEMENT

5.1 Human Resource Planning

- i. The Nursing Services shall ensure there is a system to provide appropriate numbers of nursing staff with required skills in the hospital at all times.
- ii. The Nursing Services shall be responsible for training of nursing staff to meet service needs and expansion plan of the Hospital.

5.2 Orientation

- i. Newly appointed nursing staff shall be informed about the terms and conditions of their appointment as in the General Order, *PKPA (Perintah-Perintah Am)* and Peraturan-Peraturan Pegawai Awam (Perlantikan, Kenaikan Pangkat dan Penamatan Perkhidmatan).
- ii. Orientation programme shall be organized for all new nursing staff within the first month of their reporting for duty. The orientation programme shall include overall briefing on the hospital; nursing policies and procedures; rules and regulations; and their roles and responsibilities.
- iii. Specific briefing shall be given by the various departments and units.
- iv. All the newly qualified nurses SHALL undergo a six (6) months mentorship programme and are required to pass the allocated competency examinations.

5.3 Placement

- i. Staff allocation is determined by the Human Resource Department, Ministry of Health and distribution is done by the nursing administration at the state level.
- ii. At the hospital level, the matron shall do placement of nursing personal. Categories of nursing personnel are:
 - Nursing Sister (Nurse Manager)
 - Registered Nurse
 - Community Nurse
- iii. Staff placement and deployment shall take into consideration:
 - a) Patient acuity level and workload of the specific ward/unit,
 - b) Qualification and experience of individual staff.
 - c) Contingency for absenteeism, Medical leave and emergency leave.
- iv. Placement of nursing staff to wards or units shall be based on qualification, specialized training received and service needs
- v. Nurses shall be provided with written and dated job description which defines roles and responsibilities for their designated Position
- vi. Deployment and rotation of nursing staff to another ward and unit may be carried out as and when necessary.
- vii. The Nursing Services shall be responsible for the deployment of the nursing staff. The priority and emphasis on staff strength shall be given to all the critical areas
- viii. An up-to-date registry of all the nursing and auxiliary staff shall be kept and maintained by the Nursing Services.
- ix. A report on the hospital nursing staff strength shall be sent to the State Matron's office on a monthly basis.
- x. The Nursing Services shall review the hospital's nursing staff strength and needs annually. The application for the additional nursing manpower shall be sent to the State Health Office annually and when instructed.
- xi. The Nursing Services shall ensure that all the nurses have a current and valid annual practicing certificate (APC).
- xii. The Nursing Sister of each respective discipline shall provide counseling to the Nursing staff when the need arises.
- xiii. Nurses shall be registered with the Nursing Board, Malaysia.

- xiv. Midwives shall be registered with the Midwifery Board, Malaysia

5.4 Contingency Plan for Nursing Staff Shortage

The nursing services shall provide an adequate number of nursing staff whose qualifications are consistent with job responsibilities. The nursing services shall make every effort to ensure patient care needs are met at all times despite changes in the environment of care or changes in the community.

- i. In event of a civil disturbance, natural disaster, epidemic, employee strike or walkout, available staff may be reduced because the staff will either refuse to come to hospital for safety reasons, political reasons or are physically unable to reach the hospital.
- ii. When staff shortage contingency plan has been activated, staff shall be requested to remain on duty unless authorized to leave by their supervisor.
- iii. The Hospital Administration shall notify the following via telephone when the plan is activated:

The Director of Jabatan Kesihatan Negeri Sarawak immediately upon being notified of the intent in the discontinuance or disruption of services, or upon threat of a walkout of a substantial number of employees

The Head of Nursing Services immediately upon being notified of the intent of the discontinuance or disruption of services, healthcare surge or threat of a walkout of a substantial number of employees

- i. The Ward / Unit Managers shall carry out the following procedures:

Instruct staff not to leave during an emergency or civil disturbance unless they have explicit permission from their supervisor

Request additional staff directly from the Head of Nursing Services

Provide departmental orientation material to be read by hospital personnel that are deployed from other hospital prior to commencing work

- ii. If temporary re-deployment of nursing staff is needed to meet patient care demands, it will be co-ordinated by Head of Nursing Services following procedures as outlined below:
Calling in any on-call staff
Calling in off-duty staff
Reassigning staff from a non-impacted area to an impacted area
Offering overtime to staff on or off-duty
- iii. The Hospital Director shall be kept informed by the Head of Nursing Services for any on-going shortages of staff. The Hospital Director shall consider the followings:

Implementation of the rapid discharge plan

- Cancellation of all elective surgery
- Call in off-duty staff
- Mobilization of licensed and / or non-licensed staff from the administration of non-clinical areas
- Closure of selected clinics to allow re-deployment of clinic staff
- Transfer patient to other tertiary hospital if necessary

5.4.1 Staff Deployment

Nursing shortages affect the workload of existing staff and pose a potential threat to the continuity of care and patients' safety

- i. Short-term deployment of nurses is usually used within the hospital units in order to 'balance the numbers' or to cover the shortage of staff in the different units.
- ii. Nurses in other unit are sent to go and assist in another unit, where there is not enough nursing staff or when their own unit is not busy.
- iii. The aim of deployment is to cover the shortage of nurses in the particular unit for a duty shift.
- iv. Deployment of staff shall be arranged by the ward Sister or Sister on call. Decisions will be made rapidly and communication with staff conducted verbally rather than in writing

5.5 Professional Training & Development

- i. The Nursing Services shall plan and encourage all the nurses to undergo appropriate training programme to improve their professional knowledge and skills as well as to fulfill the needs of the hospital.
- ii. The Nursing Services' office shall coordinate and assist in the application of Post-Basic Nursing Training for all nurses in the hospital.
- iii. The Nursing Services shall promote continuing professional educational activities through organization of Continuing Nursing Education (CNE) session twice monthly and other in-house training activities.
- iv. The Nursing Services shall promote, coordinate and encourage the nurses to participate in continuing professional educational activities organized by the hospital or other professional bodies.
- v. The Nursing Services shall encourage all nursing staff to participate in research and audit activities.
- vi. The Nursing Services' office shall act as a secretariat for organization of Annual Nurses Day Celebration for the Hospital.

- vi. The Nursing Services shall ensure nursing care complies to current guidelines / protocols and evidence-based practices towards ensuring the delivery of quality care as well as to ensure nurses are well prepared to response to emergency crisis and disaster.
- vii. The nurses in the ward shall submit a 24 -hour nursing and workload report to the Nursing Services' office on daily basis.
- viii. The nursing sister of the ward shall prepare weekly roster for her nursing staff. A copy of roster shall be submitted to the Nursing Services' office for records by every Thursday for roster of the following week.
- ix. The nursing sister of the ward and / or the nursing sister on general duty (after office hours) shall deploy the nursing whenever the need arises. Such deployment shall be adequately documented in the reports of nursing sister on general call duty daily.
- x. A monthly duty roster shall be drawn up for the nursing sister to be on general call duty daily.
- xi. All clinical practice guidelines (CPG) and protocols on care and management of patient shall be read, practiced and complied with to ensure compliance to standards of care.

6.2 Medical Records of Patient

- i. All BHT entry shall be documented clearly with legible hand writing. Only nationally agreed and acceptable standard abbreviations or symbols are allowed.
- ii. All BHT entry shall be dated, timed, initialed and followed by the doctors or nurses' name either stamped or hand written.
- iii. The nurse shall make documentation in the patient's bed head ticket whenever they review the progress of the patient.
- iv. All medical records of discharged patient must be kept at locked cupboard or drawer while awaiting dispatch to Medical Records Department.
- v. All investigation results received after patient discharge shall be managed in the following way depending on types of investigation:

All investigation results shall be reviewed by Medical Practitioners on a pre-determined day & time.

The Medical Practitioners who reviewed the results shall determine which unit that such results shall be dispatched to i.e. the Outpatient Department or the Medical Records Unit of the Hospital.

This information shall be clearly indicated on the results by the Medical Practitioner who reviewed the results.

Investigation results dispatched to the Outpatient Department shall be filed into the home-based card of patient during the next follow-up appointment.

Investigation results dispatched to the Medical Records Unit shall be filed into the medical record of respective patient.

- vi. All BHTs shall be dispatched to Medical Record Department within 3 working days (72 hours).
- vii. The ward Sister or Staff Nurse in-charge shall be responsible for the security and movement of all medical records of patients.

6.3 Management of Medication & Supplies

- i. Weekly checking of all medications in the floor stock, drug refrigerators, List A drug stock and after office hours stock shall be done on weekly basis by Staff Nurse in charge according to the following schedule:

Male ward – Sunday
Maternity Ward- Monday
Paediatrics ward – Saturday
Female ward – Saturday
- ii. Indenting of Dangerous Drugs (DD) from pharmacy shall be done by Staff Nurse in-charge on every Wednesday adhering to standard operating procedures.
- iii. Checking of dangerous drugs in DD cupboard shall be done once per shift by Staff Nurse in-charge and cross checking shall be done on monthly basis by the Sister in-charge.
- iv. Medication safety audits and audits on DD shall be done by Pharmacist and appointed Sisters on quarterly basis to all wards.
- v. Medications and all contents in the emergency trolley of all areas shall be checked once per shift by Staff Nurse in-charge and replenished accordingly.
- vi. Pharmaceutical supplies in store of each ward / unit shall be indented and checked on weekly basis following standard operating procedures.
- vii. Medication Error
The doctor shall be notified immediately and an incident report must be written for investigation. The nurse shall only administer medications endorsed by the medical practitioners in the patient's BHT and medication List.
- viii. All medications in High Alert Medication (HAM) list and Look-Alike-Sound-Alike (LASA) list shall be managed as per pharmacy guidelines. The following guidelines shall be complied with:

- a) Guidelines on Handling Look Alike Sound Alike Medications, 1st Edition, 2012, Pharmaceutical Services Division, Ministry of Health Malaysia
- b) Guidelines on Safe Use of High Alert Medications, 1st Edition, 2011, & 2nd Edition November 2020, Pharmaceutical Services Division, Ministry of Health Malaysia.
- c) Dilution Guide for High Alert Medication, 2011, Pharmaceutical Services Division, Ministry of Health, Malaysia

6.4 Discharge of Patient

Discharge care plan

- i. The ward doctor decides when a patient may be discharged from hospital.
- ii. Results of all investigations done in Kanowit Hospital shall be obtained and reviewed before discharge.
- iii. Doctors to write the discharge summary which shall include the outline of plan for follow-up as determined by the ward doctor.
- iv. The Nursing Sister of the ward shall be responsible for the security and movements of all the BHT. The BHT after discharge of the patient shall be dispatched to the Medical Record Unit within 3 working days (72 hours).
- v. All patients shall be charged as according to Fee Act except for communicable diseases.
- vi. All communicable disease or police case will be notified within the appropriate time frame before the patient is discharge from the hospital.
- vii. The patients shall be given the following before they leave the ward:
 - Discharge note
 - Medical leave certificate if necessary
 - Prescription slip / medication and appropriate counseling on their medications
 - Follow-up appointment date
 - Relevant medical advices / health education.

6.5 Home Leave

- i. Only the attending doctor is allowed to give home leave. The doctor shall indicate by a written order in the patient's BHT, the nature and time limit of the home leave.
- ii. The patient is required to sign in the BHT the required time of leave in the presence of a witness. The patient must return to the ward within the stipulated date and time.
- iii. The nurse shall be responsible to inform the doctor if the patient failed to return to the ward on the stipulated date and time.

6.6 Transfer of Patient from Other Hospital (Step Down care)

The following patients shall be received from the tertiary hospital:

- a) A patient with an established plan of care, who can be safely managed in a non specialized area/ non specialist hospital
 - b) A patient who has a discharge plan
- i. Any transfers in of patients shall be notified by the Transferring Hospital to the Medical practitioner / Hospital Director.
 - ii. The Transferring Hospital ward shall document the necessary instructions in the Letter of transferring in particular any special instructions for the continuation of care for the patient.
 - iii. The nursing staff in-charge receiving the patient shall check the patient's Letter of transfer ; x-ray if any; patient's; observation charts; intake/ output during handing over of the patient. She shall ensure that adequate hand over of the patient to the staff nurse in-charge of the receiving ward is done.
 - iv. The nursing staff shall document this information in the ward's registration book.
 - v. All transfer of patient shall adhere to the policy and procedures as outlined in the following document:

Policy & Procedures of Medical Escort System in Kanowit Hospital (revised 2023) SPKPK Bil. 2/2009 Garis Panduan Rujukan dan Perpindahan Pesakit di antara Hospital-hospital KKM dated May 2009.

6.7 Referral of Patient to Tertiary Hospital

- i. The doctor on duty shall consult the Specialist in Sibul Hospital if the condition of the patient needs specialist opinion and discuss the criteria for referral.
- ii. The patient shall be referred if the Specialist in Sibul Hospital agreed.
- iii. The patient shall be referred directly to the Emergency & Trauma Department, Sibul Hospital
- iv. All patients ventilated shall be transferred to Sibul Hospital.
- v. The date and time of referral shall be recorded in the referral book in the respective Ward, Hospital Kanowit.
- vi. If the Specialist does not agree for the patient to be transferred, the patient shall be admitted/ kept in our Hospital Kanowit respective ward.

6.8 Death

- i. The legal custodian shall be informed on the patient's death in the ward or by phone / radio message if the legal custodian is not available at the time of death. The cadaver shall be released to the legal custodian by the Assistant Medical Officer in-charge of Mortuary Services upon production of all relevant legal documents and copy of Medical Certificate of Death (MCD).
- ii. The cadaver shall be sent to the mortuary at the end of an hour following time of death for subsequent release to the legal custodian.
- iii. The cadaver of patient with communicable disease shall be handle in accordance with the Ministry of Health's Guidelines.
- iv. The Pembantu Perawatan Kesihatan (PPK) of Mortuary Services shall be responsible for transporting the cadaver from ward to Mortuary by using the cadaver trolley.

6.9 Patient Safety

- i. Patient identification:
 - All patient shall have an identification wrist tag during hospitalization.
 - Particulars to be written inside identification tag are: Patient's name, sex, registration number, date of admission and name of the ward.
 - Patient shall be identified using two identifiers complying to all requirements as stated in the Malaysian Patient Safety Goals.
- ii. Effective communication among care -givers:
 - A nurse shall not take verbal/ telephone order except in emergencies only.
 - Verbal and telephone communication including laboratory results and orders shall be written down by the receiver in the patient's case-notes.
 - Read back shall be done by the receiver and confirmed to be accurate by the informer.
 - Such communication shall be documented appropriately and timely in the patient's case notes by receiver immediately. The medical practitioner who gave the instructions or orders shall ensure appropriate, correct and timely documentation of such information into the patient's case notes
 - The medical practitioner must endorse and sign the orders within **24 hours**
- iii. Medical staff except the staff on duty/ staff deployed in that particular ward are not allowed to administer injection to their own relatives during hospitalization.
- iv. All syrup medication served to Pediatric patients must use an oral medication syringe.

Communication among care-givers on the care of patient shall adhere to Surat Pekeliling KPK Bil. 10/ 2016: Garis Panduan Penggunaan Media Sosial Dalam

The Quality Unit located at the Nursing Services' office shall assist the Hospital Director to compile, review all the incidents report and to initiate preliminary investigation if necessary.

6.10 Patient & Family Rights

- i. All the nurses shall ensure that the rights of patients and relatives are respected at all times. Such rights shall include right to know, right to privacy, right to confidentiality and right to choose.
- ii. Policy and procedures of Patient and Family Rights (Revised 2023) of the hospital shall be adhered to.

7. OTHER RELATED POLICIES AND PROCEDURES

The following policy and procedures shall be complied with for Nursing Services in this Hospital:

7.1 Policy & Procedures on Care & Management of Emergency Patients

Comprehensive and appropriate care shall be given to all patients requiring emergency care. All patients shall be triaged accurately and appropriate treatment shall be initiated within stipulated time frame based on their triage category. Relevant aspects of the Departmental Operational Policies & Procedures for Emergency Services shall be complied with.

7.2 Policy & Procedures on the Use of Resuscitation Services

Relevant policy and procedures as outlined in the Hospital Internal Disaster Plan – Medical Disaster Preparedness Plan (revised 2023) shall be complied with. The following colour code and procedures as spelt out in the document shall be adhered to whenever patient requires resuscitation services:

- a) Code Pink – For Infant Abduction
- b) Code Red / Red Alert– For Obstetrics & Gynecological Emergency
- c) Code Blue – For Adult Emergency
- d) Code Grey – For handling of aggressive person(s)
- e) Code Black- Bomb Threat

7.3 Policy & Procedures on Administration of Blood & Blood Products

Relevant policy and procedures as outlined in the following documents shall be complied with:

- a) Transfusion Practice Guidelines for Clinical & Laboratory Personnel 4th Edition 2016, Ministry of Health Malaysia
- b) Departmental Operational Policies & Procedures for Blood Transfusion Services, Hospital Kanowit (revised 2023)

7.4 Policy & Procedures for Patients on Life Support Equipment / Comatose Patient

Relevant policy and procedures as outlined in : Policy & Procedures for Withholding and Withdrawal of Life Support, Whole Hospital Policy (revised 2023) shall be adhered to.

7.5 Policy & Procedures on reducing the risk of hospital acquired infection in the hospital

Relevant policies and procedures as outlined in the Departmental Operational Policies & Procedures for Infection Control, Hospital Kanowit (revised 2023) shall be adhered to.

7.6 Policy for control and prevention of Tuberculosis Among Nursing Staff

Relevant policies and procedures as outlined in the following documents shall be complied with:

- a) Guidelines on Prevention & Management of Tuberculosis for Health Care Workers in the Ministry of Health Malaysia, 2012
- b) Tatacara Pelaksanaan Pekeliling Ketua Pengarah Kesihatan Bil. 9 / 2012: Proses Saringan TiBi Bagi Anggota Kementerian Kesihatan

7.7 Policy & Procedures for Patients with Communicable Diseases

Relevant policy and procedures as outlined in the following documents shall be complied with:

- a) Policies and Procedures on Infection Control 2nd Edition, 2010, Ministry of Health Malaysia
- b) Departmental Operational Policies & Procedures for Infection Control, Hospital Kanowit (revised 2023)
- c) Case Definitions for infectious diseases in Malaysia 2017 (includes notification)

7.8 Policy & Procedures for Management of Immuno-Compromised Patients

Relevant policy and procedures as outlined in the following documents shall be complied with:

- a) Policies and Procedures on Infection Control 2nd Edition, 2010, Ministry of Health Malaysia
- b) Departmental Operational Policies & Procedures for Infection Control, Hospital Kanowit (revised 2023)

7.9 Policy & Procedures for Patients on Dialysis

Relevant policy and procedures as outlined in the following documents shall be complied with:

- a) Policies and Procedures on Nephrology Services Operational Policy, Nov 2010, Ministry of Health, Malaysia
- b) Departmental Operational Policies & Procedures for Chronic Dialysis Services, Hospital Kanowit (revised 2023)

7.10 Policy & Procedures for Use of Physical Restraint on Patients

- i. Some aggressive patients will require physical restraints when de-escalation and pharmacological interventions fail or when one-to-one nursing is not feasible. However, de-escalation techniques shall be continued throughout the restraint procedure. The use of physical restraints may be necessary for the patient's own safety and protection of others.
- ii. Any decision to restrain patient and to remove the physical restraint shall be decided by the Medical Practitioner. The next of kin shall be informed the reason for restraining the patient and consent shall be taken.
The nurse shall document in the BHT:
 - Name of the next of kin
 - Date and time informed
 - The reason for restraining the patient
- iii. All aggressive or abnormal episodes shall be appropriately documented in the patient's case notes and close observation with monitoring shall be performed by the nursing staff.
- iv. The following monitoring shall be done for all patients who are on physical restraint:
Monitoring by nursing staff every 15 minutes including vital signs monitoring.
Review by medical officer at least once every 4 hours.
Review by Medical Practitioner if restraints exceed 8 hours continuously or 12 hours intermittently.
- v. Proper nursing care and attention to basic needs of patient who are on physical restraint shall be given (intake, output, bedding change, clothing change and personal hygiene).
- vi. The Four-Point Restraint Technique shall be used to restrain patient and the documentation on the restraint shall be recorded into the patient's BHT..
- vii. All other relevant policies and procedures as outlined in the following documents shall be adhered to:

Guidelines on Management of Aggressive Patients in Ministry of Health Facilities
MOH/P/PAK/323.16 (GU) (November 2016)

7.11 Policy on Care of Vulnerable (Disabled individuals & children) & Elderly Patients

- i. A vulnerable patient is someone who is or may be in need of more specialized care by reason of mental or other disability, age, or illness and who is or may be unable to take care of him / herself and protect him / herself against significant harm or exploitation and those who are ill or dependent upon another for any of the aids to daily living.
- ii. Vulnerable patients shall be given priority at all counters of the Hospital e.g. JPL, Pharmacy Counter, Payment Counter etc. as well as urgent attendance at the Emergency and Trauma Department for investigation and treatment.
- iii. They shall also be assisted with hygiene care, feeding, dressing and where necessary by the nursing personnel when they are admitted to the Hospital.
- iv. The relevant policy of the Hospital on patient and family's rights shall also be respected and upheld at all times by Hospital staff for this group of patients.
- v. All children admitted to the Hospital shall be accompanied by their parent or guardian.
- vi. A male caregiver shall be put in a separate room with the patient in the absence of a female relative. This is to protect and provide privacy to the other patients/ female caregivers in the ward.
- vii. Other patients in the vulnerable group may be accompanied by a care-giver during the whole period of admission to the Hospital.
- viii. The Hospital shall ensure adequate provision of amenities and facilities to facilitate easy movement of the disabled and elderly within the hospital environment during emergencies or wherever possible.
- ix. The Hospital shall also ensure implementation of adequate safety mechanisms within the hospital environment for these vulnerable patients.

7.12 Policy & Procedures on Patients Receiving Chemotherapy / High Risk Medications

Relevant policy and procedures as outlined in the following documents shall be complied with:

- i. Guidelines on Handling Look Alike Sound Alike Medications, 1st Edition, 2012, Pharmaceutical Services Division, Ministry of Health Malaysia

- ii. Guidelines on Safe Use of High Alert Medications, 1st Edition, 2011, Pharmaceutical Services Division, Ministry of Health Malaysia
- iii. Dilution Guide for High Alert Medication, 2011, Pharmaceutical Services Division, Ministry of Health, Malaysia
- iv. Departmental Operational Policies & Procedures for Pharmacy Services, Hospital Kanowit (revised 2023)

7.13 Policy & Procedures on Sanitation for Patients

- i. All patients on admission to the ward shall be assessed for their skin integrity using the appropriate tools as outlined in the following Nursing Assessment forms:
Braden Scale for adult patients (Refer to Nursing Assessment on Admission for Adult Form – BKJ-BOR-PPK-20 pind . 1/2016).
- ii. Skin condition and integrity for Paediatrics and Neonates (Refer to Nursing Assessment for Admission for Paediatrics & Neonates Forms.
- iii. Personal hygiene of bedridden patients shall be attended to e.g. bed bath, turning, oral toilet and changing to ensure the patients are clean and dry at all times. Such patients are kept dry by using talcum powder or lotion where relevant.
- iv. The staff shall ensure that the patient is kept clean and dry when doing 2 hourly turning of bedridden patient.
- v. Patient shall be guided to the bathroom and toilet and be allowed to bath themselves if they are able to do so.
- vi. Bed linens shall be changed at least once a day to improve comfort and to maintain high level of hygiene.
- vii. Hair brushing / shampooing, shaving and nail trimming shall be done regularly to maintain the patient's physical appearance.
- viii. Urinary catheter shall be changed every two weeks to reduce infection for patient on long term catheterization.

7.14 Policy & Procedures on Food and Nutrition for Patients

- i. Routine nutritional screening is carried out within 24 hours of admission to hospital (Refer to Nursing Assessment on Admission for Adult Form BKJ-BOR-PPK-20 pind.1/2016; Nursing Assessment on Admission for Paediatrics & Neonates)
- ii. Meals are served in a timely manner once ready.

- iii. Food is served at the correct temperature.
- iv. The Dietetic Department shall be informed if a patient requires a therapeutic diet.
- v. The Dietetic department shall be informed if a patient requires an alternative diet for religious or cultural reasons.
- vi. Wards are sufficiently staffed at mealtimes to ensure all patients receive adequate attention during mealtimes especially for patients who need assistance.
- vii. Drinks are made available during mealtimes and throughout the day.
- viii. Warm drinks shall be served to patients after delivery.
- ix. Nasogastric feeding tube shall be changed every two weeks for patients who require long term nasogastric feeding.
- x. Advice on parenteral nutrition composition and compatibilities shall be obtained from the Clinical Pharmacists. Appropriately qualified pharmacists shall dispense parenteral feeds, fluids and other necessary therapy.

7.15 Policy & Procedures of Treatment for Patients

- i. All drugs shall be prescribed by the Medical Practitioner in the patient's drug chart. All prescribed drugs must be signed and dated.
- ii. Treatment ordered by the Medical Practitioner shall be carried out promptly by the nursing staff and this should be documented accordingly.
- iii. 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 by use of screens.
- iv. In emergency situation or life-saving situation, the Medical Practitioner in-charged or on-call shall be informed immediately and request for help from nursing staff from another ward shall be obtained. The nursing staff is allowed to give stat dose of drugs ordered verbally by the Medical Practitioner. This order of drugs shall be endorsed and indented by the Medical Practitioner concerned later.
- v. All medication shall be served to the patient according to the patient's medication sheet as ordered by the Medical Practitioner and this shall be carried out by a qualified nursing staff and witnessed by a second nursing staff.
- vi. Privacy of patient shall be ensured when examination of patient is done during Medical Practitioner's or nursing's rounds.
- vii. The medication list must be dated, timed and signed by both the nursing staff who served the medication and the nursing staff who witness the administration of the medication to the patient. In event where there is only 1 nursing staff working in

that shift, the witness shall be the Nursing Sister in-charge or nursing staff that is deployed from another ward.

- viii. All treatment ordered shall also be documented in the patient's BHT.

7.16 Policy & Procedures on Prevention of Fall among Patients in Hospital

- i. Routine assessment on risk of fall among all patients shall be carried out within 24 hours of admission to hospital (Refer to Nursing Assessment on Admission for Adult Form BKJ-BOR-PPK-20 pind.1/2016; Nursing Assessment on Admission for Paediatrics Form).
- ii. Risk of fall among adult patients shall be assessed using the Morse Fall Score while risk of fall among paediatrics patients shall be assessed using the Humpty Dumpty Fall Assessment Scale Chart.
- iii. Subsequent assessment on risk of fall shall be assessed once a day and when there is a change in the patient's condition for patients that have been identified in initial assessment to be at risk of fall using the following fall risk assessment forms:
 - iv. Adult patients - BKJ-BOR-PPK-fall 2 (pind. 2/2018) Morse Fall Scale Assessment Chart
Paediatrics patients – BKJ-BOR-PPK-fall 6 Pind 1/2018 Humpty Dumpty Fall Assessment Scale Chart (Paediatric)
 - v. A colour coding signage shall be used and put at head of patient's bed to alert nursing staff on patients who have been identified to be at risk of fall. This colour coding system shall be that of **YELLOW** and **RED** depending on the score in the appropriate assessment chart as outlined below:
Medium risk for adults & low risk for Paediatrics – Yellow Tag
High risk for both adults & Paediatrics – Red Tag
 - vi. The appropriate Patient Fall Safety Protocol as outlined in the related checklist shall be implemented for all patients that have been identified to be at risk of fall while being admitted to the Hospital.

Appropriate documentation shall be done by nursing staff in the patient's progress notes on fall assessment and strategies that have implemented for patient at risk of fall.

7.17 Policy on patient participation in their care and treatment.

- i. Patients' participation in decision making in health care and treatment are encouraged to reduced likelihood for medical errors and are in low risk for relapse and poor health outcomes.

- ii. They should collaborate with their medical practitioner to better understand aspects of their disease, so as to actively participate in treatment decisions and provide their informed consent to any treatment plan

7.18 Policy on Do Not Resuscitate

Relevant policy and procedures as outlined in : Policy & Procedures for Do Not resuscitate, Hospital Kanowit (revised 2023) shall be adhered to.

7.19 Policy on Informed consent

Relevant policy and procedures as outlined in : Policy & Procedures for Informed Consent, Hospital Kanowit (revised 2023) shall be adhered to.

7.20 Policy on end of life care

- i. Symptom control (e.g. relief of pain and other discomforts) all medications, must be targeted at specific symptoms. Referrals to medical practitioner must be undertaken if adequate pain relief is not being achieved.
- ii. Food and fluid intake
The patient will be supported to eat and drink as long as they wish to do so. Nursing staff will assess and monitor nutritional and fluid status and an alternative method of hydration considered if the patient is at risk of choking/ aspiration.
- iii. Assessment of the dying persons comfort and dignity must be documented in the care plan and include personal and mouth care delivered, equipment used e.g. ripple mattresses and bedrails
- iv. If the person lacks capacity to make decisions then any decisions made must be in the person's best interests
- v. The dying persons religious/spiritual needs must be considered. Staff must seek to establish from the dying person, their family and those important to them, details of any relevant cultural or religious-specific requirements, including what constitutes respectful treatment of the body after death.

7.21 Policy on Management of patient under police custody

Staff providing care to patient in police custody

- i. Detainees in custody are entitled to doctor-patient confidentiality and professionalism.
- ii. Staff providing care to detainees must always be vigilant to their personal safety. This includes the use of personal protective equipment, use of proper safe distance during care and proper management of sharp instruments
- iii. It is advisable to have early specialist consultations for detainees in custody.

Examination and treatment of patients in police custody

- i. The accompanying Custody Officers should be facilitated to have sight of the detainee without compromising patient's privacy and privileged doctor patient communication.
- ii. Law Enforcement restraint devices on detainees such as handcuffs should only be removed during life threatening emergencies, if deemed necessary.
- iii. Detainee's right and consent to treatment should be respected at all time. Thus, consent procedures are the same as any other patient.
- iv. Accompanying Custody Officers have no legal authority to provide consent on detainee's treatment.
- v. A detainee has the right to refuse examination or intervention. This should be clearly documented in the clinical notes together with the appropriate advice provided by the MO.
- vi. Doctor-patient confidentiality applies to detainees. Consent from detainees is required for disclosure of clinical information.
- vii. If a detainee is critically ill, the MO must inform accompanying Custody Officers on the detainee's status. This would facilitate detainee's family notification by the Lock-up Supervisor

7.22 Policy on Bed management

Bed management is the allocation and provision of beds in a hospital

Bed Capacity and Patient Flow Management Bed management responsibilities will be undertaken by the Ward Manager. After Office Hours, Night Nurse will coordinate bed management.

Hospital Kanowit Bed capacity is as follows:

Maternity Ward – 19 beds

Male ward – 25 beds

Female Ward – 28 beds

Paediatric Ward – 28 beds

Bed Management responsibilities

- i. Bed states will be undertaken at 08:00hrs by the Sister on call who will contact each ward. The nurse in charge of each ward is responsible for ensuring that an accurate bed state is communicated including the number of vacant beds at the time.

- ii. To take action to address any shortfall in bed capacity against requirement in order to ensure safe patient placement.
- iii. Review expected capacity on each ward including confirmation that existing patients have been reviewed and confirm any discharges.
Ascertain admissions and transfers from:
 - a) Elective / Waiting List admissions
 - b) Transfers from other Hospital
 - c) All admissions must be arranged through the charge nurse.
 - d) In hours any escalation of bed pressures must be reported to the Sister in charge/ Matron. The sister in charge will provide relevant information in relation to:
 - bed availability,
 - expected admission and discharges,
 - current pressures.

8.0 FACILITIES & EQUIPMENT

- i. The nursing sister/ Staff Nurse in charge shall indent surgical supplies, drugs and non-drug items from pharmacy and stores on regular basis to ensure sufficient stock is available at all times.
- ii. The ward sister in-charge shall maintain an updated inventory of all ward equipment and assets. She shall ensure all equipments are regularly maintained in good functioning condition by the concession company.
- iii. The contents of the emergency trolley shall be checked every shift and replenished accordingly.
- iv. The Chief Matron shall ensure that all services provided by concession company are of acceptable standards and quality as stipulated in the concession agreement. Regular meetings shall be held with concession company to discuss any issues pertaining to the level of services given and to validate that appropriate services have been given.
- v. An inventory of the office equipment and an index of the filing systems of nursing services shall be maintained and kept in order.

9.0 SAFETY & PERFORMANCE IMPROVEMENT ACTIVITIES

All staff and patients involve in performance improvement activities are kept private and confidential

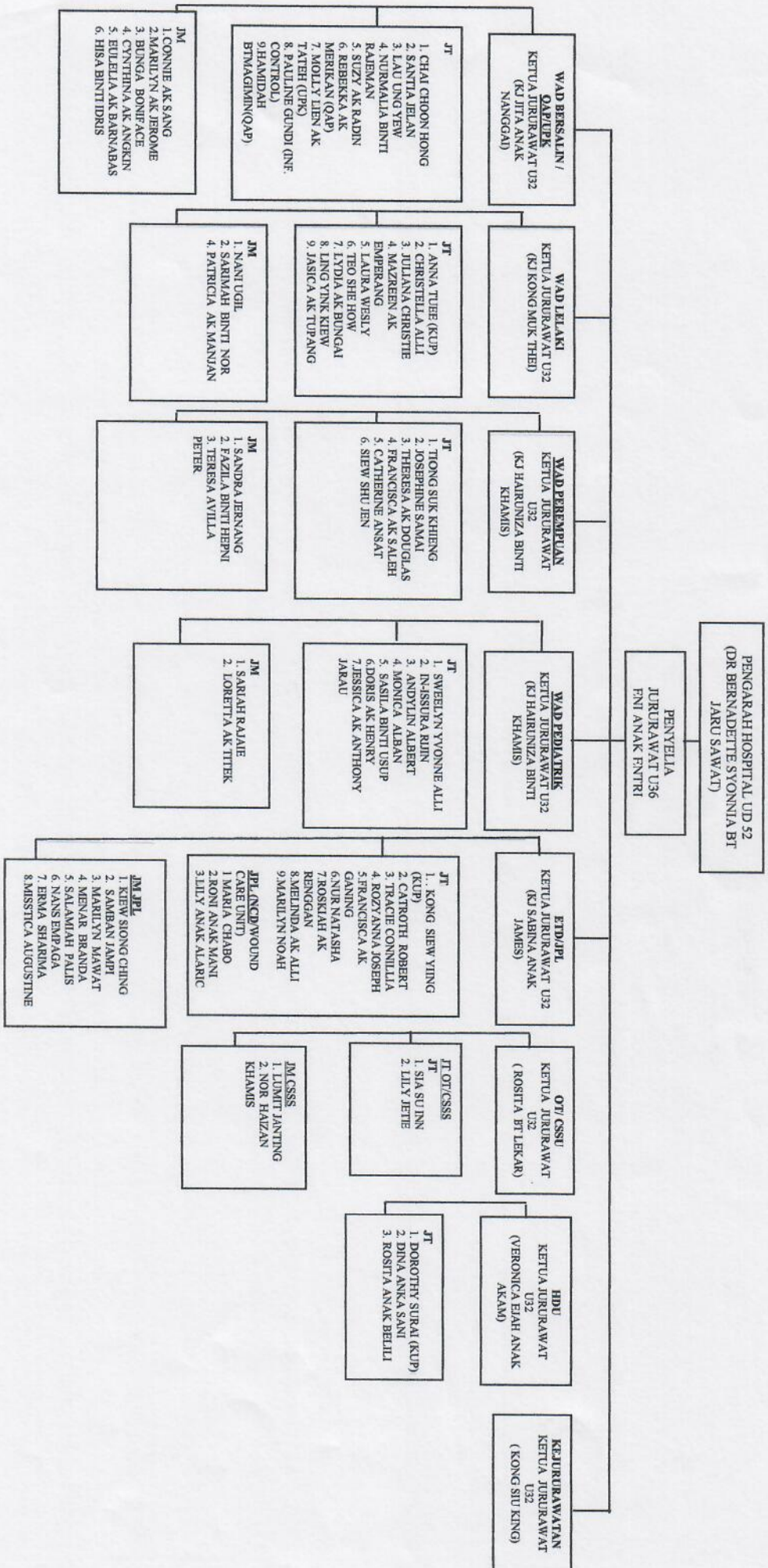
The following shall be used to appraise and ensure the safety and quality of nursing services in this hospital:

- i. 3 Monthly nursing management meetings
- ii. 2 monthly monitoring and evaluation of nursing practices through Clinical Skills Assessment by nursing sisters in all clinical areas
- iii. 6 monthly National Nursing Audits on nursing practice
- iv. Regular evaluation of compliance to standards of good nursing practice by the nursing sister during general call duty via targeted objective rounds
- v. 6 monthly annual client satisfaction survey using SERQUAL Methodology for both in-patients and out-patients in the hospital
- vi. Monthly monitoring, tracking and trending on rate of pressure ulcers, thrombophlebitis and fall with appropriate analysis and evaluation done on SIQ factors using Root Cause Analysis concept.
- vii. Monthly monitoring tracking and trending on Hospital Performance Indicator for accountability (HPIA)
- viii. Quality Improvement Projects (QI) & Quality Assurance Projects (QAP)
- ix. All relevant performance indicators of MSQH & the Ministry of Health
- x. Hospital Specific Approach Indicators on performances of nursing services specific to this hospital
 - i. Regular reviews on incident reports pertaining to patient safety and nursing services via root cause analysis and risk management meetings.

10.0. KEYS ASPECTS OF THE WHOLE HOSPITAL POLICIES

Relevant aspects for the whole hospital policies shall be complied

CARTA ORGANISASI SEKSYEN KEJURURAWATAN HOSPITAL KANOWIT





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POLICY ON UNIDENTIFIED PATIENT

Unidentified Patient – when a patient is brought to the Emergency Department without any identification and is not able to self-identify.

The patient's identity should be verified by asking a relative or carer the patient's name, date of birth and address.

1. In the event of the patient's name is not known, the admission staff member will review the personal belongings and hospital records to determine if there is any information regarding patient's identity.
2. The inability to clearly identify the patient must be clearly documented in the patient's health record.
3. If initial identification efforts fail, a police report shall be completed for an unidentified living/deceased person.
4. The patient will be registered into the hospital database and an identification band with the hospital registration number must be applied. A last name of X and a first name of either Male or Female which will be dependent on their gender. Eg Mister X or Miss X
5. Should there be multiple unidentified patients admitted during a disaster or other such incident; they will be registered as follows: Mister X 1, Mister X 2, etc. The unidentified patient will be issued with wristband and labels that have 'Mister/Miss X'
6. Detailed physical descriptions should be entered into the database. This will enable staff to more readily search for a patient should there be an inquiry from the public or a family member.
7. If initial identification efforts fail, the admissions staff will request that a police report be completed for an unidentified living/deceased person.
8. Information containing a photo as well as a description of the missing person shall be submitted to the media by the police for assistance to identify the patient.
9. The hospital shall contact "Jabatan Pendaftaran Negara" to request that fingerprints of the unidentified patient be taken and processed.
10. When identification of a patient is made known, the Manager in the Admitting Department is to be notified immediately so that the system and all records shall be updated.

'KAMI SEDIA MEMBANTU'

'PENYAYANG.PROFESIONALISME.KERJA BERPASUKAN'





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Disemak semula oleh:

Eni anak Entri
 Penyelia Jururawat U36
 Hospital Kanowit
 Tarikh: 14.11.2023

Disahkan oleh: DR. BERNADETTE SYONNIA BT. JARU SAWAT
 PENGARAH HOSPITAL,
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Dr Bernadette Syonna binti Jaru Sawat
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 Tarikh: 14.11.2023

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