SIBU HOSPITAL

WHOLE HOSPITAL POLICY

REVISED: MARCH 2024
NEXT REVIEW DATE: MARCH 2027

DR NANTHAKUMAR A/L THIRUNAVUKKARASU

HOSPITAL DIRECTOR

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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 4 divisions i.e. Sibu, Kapit, Mukah, and Sarikei. Under Ministry of Health's Cluster Hospital Initiative, Sibu Hospital is the lead hospital for Sarawak Central Cluster Hospital and receives referrals of patients primarily from the non-lead hospitals: Kanowit, Kapit and Daro Hospitals. In addition, some cases from Mukah, Dalat, and Sarikei and some urgent cases from Bintulu Hospital of Bintulu division are also transferred to Sibu Hospital for further assessment and management.

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:
- quality
- innovation
- health
- promotion
- respect for human dignity

iv. which promotes individual responsibility and community participation towards an enhanced quality of life

1.1.2 Sibu Hospital

a. Vision

To Care with Passion

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 emphasizing 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
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
  - Nephrology
  - Neurology
  - Endocrinology
  - Geriatrics
  - Respiratory medicine
  - Dermatology
- General Surgery
  - Colorectal surgery

- Neurosurgery
- General Paediatrics
- Obstetrics & Gynaecology
    - Gynae-oncology
- Orthopaedics
- Ophthalmology
- Otorhinolaryngology
- Psychiatry
- Oromaxillofacial Surgery
- Paediatric Dental
- 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
- Forensic Medicine Services
- Pharmacy Services
- Rehabilitation Medicine
- Physiotherapy
- Occupational Therapy
- Medical Social Welfare
- Medical Counseling
- Health Education services
- 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. Clinical Departments shall be headed by resident specialists. Non-clinical departments/units shall be headed by officers trained in the respective disciplines.

2.3 Hospital Management

The hospital management is assisted & coordinated by various management & advisory committees of the hospital such as Hospital Management Committee, Medical and Dental Advisory Committee, Hospital Privileging Committee, Hospital Patient Safety and Management Review Committee, Hospital Houseman Training Committee, Hospital Drugs and Therapeutic Committee, Hospital Medical Records Committee, Hospital Infection & Antibiotics Control Committee, Environmental Health & Safety Committee, etc.

2.4 Management Matron

The Management Matron, assisted by Area Matrons, Matrons and Nursing Sisters, shall manage all aspects of nursing services. She shall also be directly responsible for some services such as CSSD, laundry and linen services.

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 some services such as porter services, facility & engineering management services, fire safety and flood safety.

2.6 Administrative 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, ICT etc. The Administrative and Diplomatic Officer shall also be responsible for coordinating the security services.

2.7 Hospital Support Services

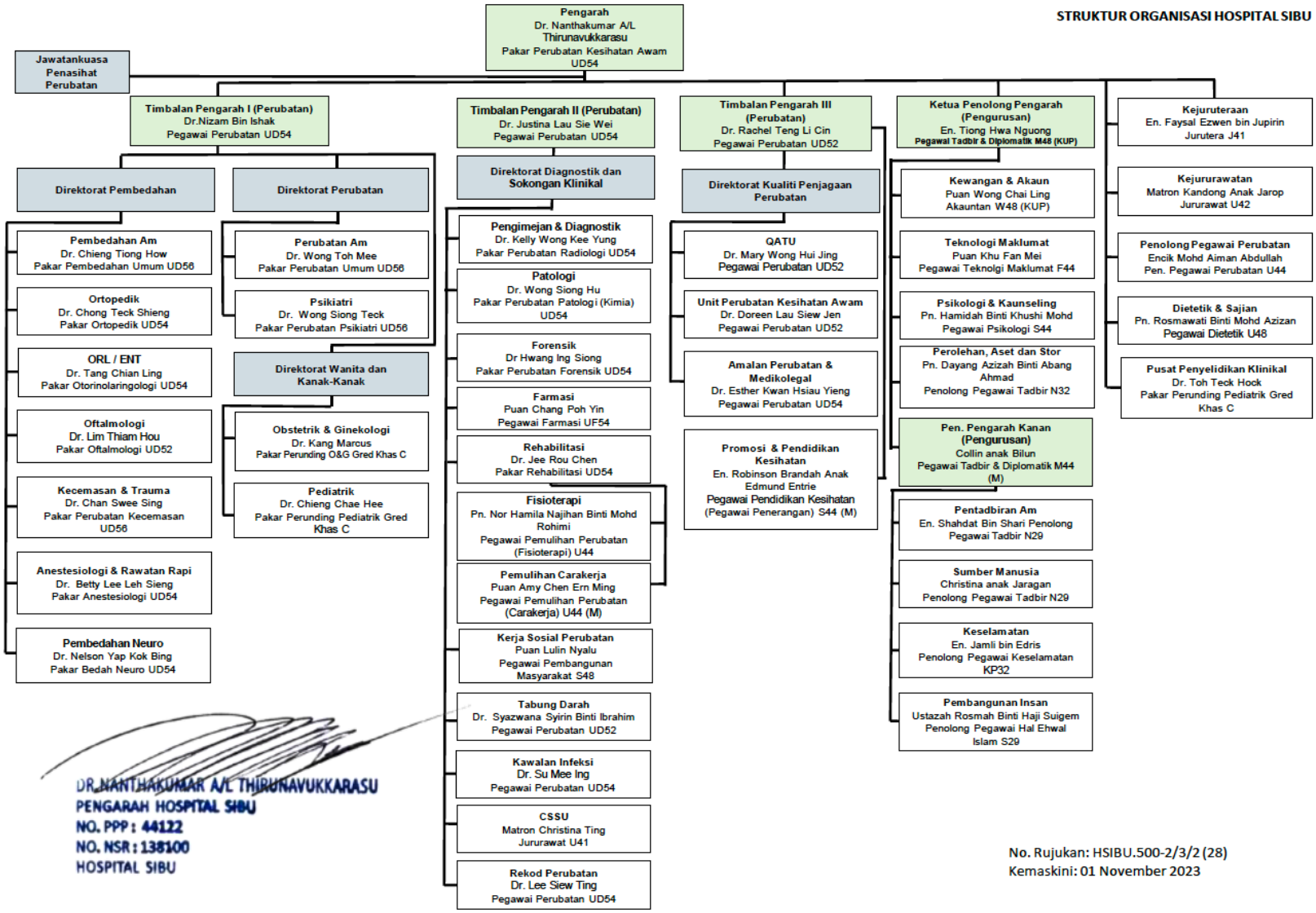
The Hospital Support Services shall follow the Concession Agreement, TRPI, MAP and HSIP for the five privatized services – Facility Engineering Maintenance Services, Biomedical Engineering Maintenance Services, Cleansing Services, Linen and Laundry Services and Clinical Waste Management Services. The services will be overseen by the hospital engineer and Administrative and Diplomatic Officer as the Chief Liaison Officer.

Liaison Officers are appointed to assist in monitoring the works carried out by the Hospital Support Services.

2.8 Overall Organization

The overall organization of the hospital is shown in the organization chart in Appendix 1.

Appendix 1


STRUKTUR ORGANISASI HOSPITAL SIBU
Pengarah
Dr. Nanthakumar A/L Thirunavukkarasu
Pakar Perubatan Kesihatan Awam UD54
Jawatankuasa Penasihat Perubatan
Timbalan Pengarah I (Perubatan)
Dr.Nizam Bin Ishak
Pegawai Perubatan UD54
Timbalan Pengarah II (Perubatan)
Dr. Justina Lau Sie Wei
Pegawai Perubatan UD54
Timbalan Pengarah III (Perubatan)
Dr. Rachel Teng Li Cin
Pegawai Perubatan UD52
Ketua Penolong Pengarah (Pengurusan)
En. Tiong Hwa Nguong
Pegawai Tadbir & Diplomatik M48 (KUP)
Kejuruteraan
En. Faysal Ezwen bin Jupirin
Jurutera J41
Direktorat Pembedahan
Direktorat Perubatan
Direktorat Diagnostik dan Sokongan Klinikal
Direktorat Kualiti Penjagaan Perubatan
Kejururawatan
Matron Kandong Anak Jarop
Jururawat U42
Pembedahan Am
Dr. Chieng Tiong How
Pakar Pembedahan Umum UD56
Perubatan Am
Dr. Wong Toh Mee
Pakar Perubatan Umum UD56
Pengimejan & Diagnostik
Dr. Kelly Wong Kee Yung
Pakar Perubatan Radiologi UD54
QATU
Dr. Mary Wong Hui Jing
Pegawai Perubatan UD52
Kewangan & Akaun
Puan Wong Chai Ling
Akauntan W48 (KUP)
Penolong Pegawai Perubatan
Encik Mohd Aiman Abdullah
Pen. Pegawai Perubatan U44
Ortopedik
Dr. Chong Teck Shieng
Pakar Ortopedik UD54
Psikiatri
Dr. Wong Siong Teck
Pakar Perubatan Psikiatri UD56
Patologi
Dr. Wong Siong Hu
Pakar Perubatan Patologi (Kimia) UD54
Unit Perubatan Kesihatan Awam
Dr. Doreen Lau Siew Jen
Pegawai Perubatan UD52
Teknologi Maklumat
Puan Khu Fan Mei
Pegawai Teknologi Maklumat F44
Dietetik & Sajian
Pn. Rosmawati Binti Mohd Azizan
Pegawai Dietetik U48
ORL / ENT
Dr. Tang Chian Ling
Pakar Otorinolaringologi UD54
Direktorat Wanita dan Kanak-Kanak
Forensik
Dr Hwang Ing Siong
Pakar Perubatan Forensik UD54
Amalan Perubatan & Medikolegal
Dr. Esther Kwan Hsiau Yieng
Pegawai Perubatan UD54
Psikologi & Kaunseling
Pn. Hamidah Binti Khushi Mohd
Pegawai Psikologi S44
Perolehan, Aset dan Stor
Pn. Dayang Azizah Binti Abang Ahmad
Penolong Pegawai Tadbir N32
Pusat Penyelidikan Klinikal
Dr. Toh Teck Hock
Pakar Perunding Pediatrik Gred Khas C
Oftalmologi
Dr. Lim Thiam Hou
Pakar Oftalmologi UD52
Obstetrik & Ginekologi
Dr. Kang Marcus
Pakar Perunding O&G Gred Khas C
Farmasi
Puan Chang Poh Yin
Pegawai Farmasi UF54
Promosi & Pendidikan Kesihatan
En. Robinson Brandah Anak Edmund Entrie
Pegawai Pendidikan Kesihatan (Pegawai Penerangan) S44 (M)
Pen. Pengarah Kanan (Pengurusan)
Collin anak Bilun
Pegawai Tadbir & Diplomatik M44 (M)
Kecemasan & Trauma
Dr. Chan Swee Sing
Pakar Perubatan Kecemasan UD56
Pediatrik
Dr. Chieng Chae Hee
Pakar Perunding Pediatrik Gred Khas C
Rehabilitasi
Dr. Jee Rou Chen
Pakar Rehabilitasi UD54
Pentadbiran Am
En. Shahdat Bin Shari Penolong
Pegawai Tadbir N29
Anestesiologi & Rawatan Rapi
Dr. Betty Lee Leh Sieng
Pakar Anestesiologi UD54
Fisioterapi
Pn. Nor Hamila Najihan Binti Mohd Rohimi
Pegawai Pemulihan Perubatan (Fisioterapi) U44
Sumber Manusia
Christina anak Jaragan
Penolong Pegawai Tadbir N29
Pemulihan Carakerja
Puan Amy Chen Ern Ming
Pegawai Pemulihan Perubatan (Carakerja) U44 (M)
Keselamatan
En. Jamli bin Edris
Penolong Pegawai Keselamatan KP32
Pembedahan Neuro
Dr. Nelson Yap Kok Bing
Pakar Bedah Neuro UD54
Kerja Sosial Perubatan
Puan Lulin Nyalu
Pegawai Pembangunan Masyarakat S48
Pembangunan Insan
Ustazah Rosmah Binti Haji Suigem
Penolong Pegawai Hal Ehwal Islam S29
Tabung Darah
Dr. Syazwana Syirin Binti Ibrahim
Pegawai Perubatan UD52
Kawalan Infeksi
Dr. Su Mee Ing
Pegawai Perubatan UD54
CSSU
Matron Christina Ting
Jururawat U41
Rekod Perubatan
Dr. Lee Siew Ting
Pegawai Perubatan UD54
DR.NANTHAKUMAR A/L THIRUNAVUKKARASU
PENGARAH HOSPITAL SIBU
NO. PPP : 44122
NO. NSR : 138100
HOSPITAL SIBU
No. Rujukan: HSIBU.500-2/3/2 (28)
Kemaskini: 01 November 2023

3. 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, faxes and e-mail communication.

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 with the procedures and guidelines issued by National Archive Department *(Jabatan Arkib Negara).*

3.1.2 Office Equipment and Supplies

i. The Asset & Procurement Unit shall coordinate the acquirement of office equipment and supplies 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.

3.1.3 Meeting Room Facilities

i. The use of meeting rooms and various seminar rooms shall be coordinated. A designated person or unit 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 the relevant department.

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

iii. The "*Pekeliling Perbendaharaan-AM: Tatacara Pengurusan Aset Alih Kerajaan"* shall be adhered to. The hospital's Asset & Procurement Unit and the appointed personnel shall be responsible for the following functions i.e. receiving, registering, usage, safekeeping, inspection, maintenance and disposal.

iv. All procurement related to ICT need approval from MOH and other relevant agencies.

v. Refer to *Arahan Perbendaharaan Bab A-Bab C* and *Surat Pekeliling Am KKM Bil 1/2016 – Tatacara Pelaksanaan Projek ICT di KKM.*

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 *Elaun dan 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 with the Fee Order (Medical) 1982, Fee Order (Medical) (Amendment) 2017, Fee Order (Medical) (Amendment) (Foreigner) 2003, Fee Order (Medical) (Full Paying Patient) 2007, Fee Order (Medical) (Cost of Service) 2014 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 may be exercised according to the Treasury Instruction/ MOH Circulars and Fee Order (Medical) (Amendment) 2017.

v. Refer to (i) Fee Order (Medical) (Amendment) 2017, (*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 Ke atas* (iv) *Surat Pekeliling Bahagian Kewangan Bil 1/2014 – Garispanduan Pelaksanaan Perintah Fi (Perubatan)(Kos Perkhidmatan) 2014*.

3.3.2 Billing & Payment

i. For paying patients, 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 staff 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, bank draft, bankers' cheque, online banking or credit/debit card. E-wallet will be implemented in near future as another option of cashless payments. 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 with 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 Pangkat dan 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 another 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 punch card. Staff requesting for time-off during office hours shall apply using the required online form in HRMIS (*Kebenaran Untuk Meninggalkan Pejabat Dalam Waktu Bekerja Di bawah Perintah Am 5 Bab G: Borang Permohonan Kebenaran Meninggalkan Pejabat Dalam Waktu Bekerja)* and obtain approval from respective heads.

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. Use of HRMIS for annual leave application is a must.

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.*

3.4.1.4 Licensing

i. Staff requiring license to practice must have license renewed annually.

ii. Eligible Specialist must be registered with National Specialist Register as per requirement of the Medical (Amendment 2012) Act 1971.

3.4.1.5 Staff Safety

i. Hospital management shall provide environment conducive for the staff to achieve organizational goals.

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

iii. Hospital Environmental Safety & Health Committee shall facilitate safety regulations and minimize risk to patients, staff, visitors and contractors.

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

v. Staff must adhere to universal precaution and all guidelines regarding infection control.

vi. Occupational and infectious diseases shall be notified accordingly.

3.4.1.6 Staff Welfare

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

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

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

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

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

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

vii. Staff Clinic is provided for staff.

3.4.1.7 Staff Ethics & Discipline

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

ii. Staff shall observe relevant professional codes of ethics.

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

iv. Staff who are required to wear uniform shall be in uniform while on duty.

v. Name tags shall be worn by all staff while on duty.

vi. Staff shall not smoke within the hospital ground.

vii. All staff should comply with the Medical Bylaws and Client's Charter at all times.

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

ix. Monitoring of staff performance shall be continuous. Staff with disciplinary problems shall be given counseling before being referred for disciplinary action. Refer to *Perintah Am Bab D Tatatertib* for disciplinary actions.

x. Gifts received should be in accordance with existing guidelines and adhered 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.*

xi. 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.

3.4.2 Professional Development and Staff Appraisal

i. The hospital management shall facilitate Continuous Medical Education (CME) and Continuous Professional Development (CPD) activities in the hospital.

ii. Staff shall be responsible for their own professional development to improve work performance. The Head of Department/Unit shall suggest appropriate training based on training need analysis for individual staff to develop their knowledge and skill.

iii. Every staff shall have own *myPortfolio* in HRMIS which contain the job description, responsibilities and work guidelines and procedures.

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

v. Staff should be appraised by respective heads annually based on the agreed performance indicators.

vi. Performance evaluation 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 they shall abide to the road traffic rules and regulation at all times.

iv. The ambulances shall be under the responsibility of the Emergency & Trauma Department whilst the other vehicles will be under the General 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 paediatrics 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, and (ii) *SPKPK Bil. 17/2012 Penambahbaikan Garis Panduan Latihan Pemanduan Ambulan KKM*, dated 16 May 2012.

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 Act (Medical) (Amendment) 2017.

3.5.2 Porter Service

There are two types of porter service: central and unit level. The functions shall be carried out by health attendants (PPK).

The central porter service is under the management of Assistant Medical Officer Administration. It is divided into several smaller teams. They shall be responsible for routine functions as follows:

A. **Transport/Food porter**

i. Sending patients from wards to OT or another unit for procedures and sending them back afterwards.

ii. Delivering food trolleys from the kitchen to all the wards. Collecting the utensils and trolleys from the wards and sending them back to the kitchen according to schedule.

B. **Specimen porter**

i. Sending routine laboratory specimens regularly according to schedule from all the wards.

ii. Delivering clean specimen containers and laboratory test results.

C. **Despatch porter**

i. Collecting and sending documents from all wards to another unit or office as instructed.

ii. Collecting and sending forms or letters from all wards to the office as instructed.

iii. Despatch BHT from all wards to Medical Record Unit.

D. **Runner porter**

i. Collect and send lotion ordering forms from all wards to pharmacy.

ii. Doing any errant jobs if needed.

iii. Standby as supporting staff during emergencies/disasters.

E. **Heavy porter**

i. Collect empty Oxygen tanks and delivering full tanks to all wards (as per schedule)

ii. Delivering supplies (pharmacy and pharmacy store) & surgical store supplies (as per schedule)

The unit level porter service will carry out porter functions outside the operating hours of central porter service and urgent tasks during office hours.

3.6 Visiting Hours

3.6.1 General

i. Visiting hours shall be determined by the hospital management depending on current health situation such as H1N1 or COVID-19 infection. Currently the visiting hours of the hospital is as follows:

<table>
<tr><th>No</th><th>Clinical areas</th><th colspan="2">Visiting Hours</th></tr>
<tr><td rowspan="2">1</td><td rowspan="2">Postnatal ward (Ward 5)
Antenatal ward (Ward 7)</td><td rowspan="2">Daily</td><td>12:00 pm – 02:00 pm
05:00 pm – 07:00 pm</td></tr>
<tr></tr>
<tr><td>2</td><td>Labour ward (Ward 8)</td><td colspan="2">Special permission from Labour ward’s doctor only</td></tr>
<tr><td rowspan="2">3</td><td rowspan="2">Intensive Care Unit (Ward 4)
ID ICU (Ward 21)</td><td rowspan="2">Daily</td><td>6:00 am – 7:00 am
12:00 pm – 02:00 pm
05:00 pm – 07:00 pm</td></tr>
<tr></tr>
<tr><td>4</td><td>SCN / NICU (Ward 3)
PICU (Ward 30)</td><td colspan="2">2 visitors allowed at all times
(Visitor’s pass required)</td></tr>
<tr><td rowspan="2">5</td><td rowspan="2">General Wards</td><td>Monday - Friday</td><td>12:00 pm – 2:00 pm
5:00 pm – 7:00 pm</td></tr>
<tr><td>Saturday, Sunday and public holidays</td><td>12:00 pm – 07:00 pm</td></tr>
<tr><td>6</td><td>ID Ward (Ward 6)
COVID-19 Ward (Ward 10)
High Dependency Ward (Ward 20)</td><td colspan="2">2 visitors allowed during general wards’ visiting hours (Visitor’s pass required)</td></tr>
</table>

ii. During visiting hours, relatives shall be allowed to visit patients in the general wards. Under certain conditions, the visitors may be asked to leave earlier e.g. for procedures and treatment.

iii. Visit to the critical care areas shall also be restricted to two visitors per patient during visiting hours.

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

v. Special approval to allow more than 2 individuals at any time can only be granted by managing doctors or Nursing Sister of the respective ward for certain situations e.g. critically ill patient or emergency situations.

vi. Refer to: *Edaran* Visiting Policies For Caregivers and Visitors at Ministry of Health Hospitals for COVID-19 patients (Updated August 2023) dated 30 August 2023.

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 caregiver accompanying the patient. Two visitor passes will be issued per patient. After visiting hours, any visit shall not exceed more than half an hour.

ii. One relative per adult patient is allowed to accompany patient in Medical, Surgical, Orthopedic and EENT & Neurosurgical wards. As for Gynecology and Maternity wards, one female relative is allowed to accompany patient.

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 paediatric 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 are not threatened.

iv. No caretaker 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 8.00 pm.

ii. Members of the Board of Visitors with identification cards shall be allowed to enter the hospital at any time 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 members.

v. Members of Women's Breastfeeding Support Group with identification cards shall be allowed to enter the hospital to assist mothers with breastfeeding support and perform formal breastfeeding related activities at Paediatric and O&G departments.

3.7 Traffic Control

i. The hospital shall implement a traffic system within the hospital to avoid traffic congestion. Road to the Emergency and Trauma Department (ETD) and Labour room shall strictly not be blocked by vehicles.

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 Management & Monitoring

The management of the hospital security is under the purview of the Hospital Management Committee, Environmental Safety and Health Committee with Hospital Security Subcommittee. Both the Hospital Management Committee and the Environmental Safety and Health Committee are under the leadership of the Hospital Director. The Committees shall ensure that effective and efficient security system is placed in the hospital.

The daily operation of the security personnel is under the monitoring of Security Unit.

3.8.2 Coordinator

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

3.8.3 Placement of security guards & Patrols

The different areas in the hospital shall be identified either as high, medium and low security. Examples of high security area are the entrances, revenue unit, intensive care units, delivery suites, stores and ICT department inclusive of server room. Areas identified as high or medium security i.e. Medical Record Department, Maternity, NICU/SCN, Paediatric wards, Medical Store, Pharmacy and Psychiatric wards shall have security measures installed or security guards placed full time. Other areas shall have a regular site patrol by the security guards.

Security service for the hospital grounds is privatized.

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.

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, *(iv) Surat Pekeliling Ketua Setiausaha KKM Bil. 10/2019 – Dasar Keselamatan ICT KKM Versi 5.0 (2019)*.

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. Refer to *SPKPK Bil.2/2000 Garis Panduan Menguruskan Harta Benda dan Wang Tunai Pesakit* dated 18 February 2000.

3.8.6 Security of baby

There must be security at the entrance of wards with baby to ensure all baby discharges have been double checked and documented. All the visitors entering wards with babies or children regardless of during visiting or non-visiting hours must be registered upon entering and leaving the wards. 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, Specialist Clinic, Psychiatric Specialist Clinic and Emergency & 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. Banking in of revenue shall be done on a daily basis for all working days.

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 The medical records room

The medical records room shall have security access door, safety grills and fireproof doors and walls as security precautions.

3.8.10 Security in Departments/ Units

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

3.8.11 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.

3.8.12 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.

3.8.13 Visitors

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

3.8.14 Spare keys

A set of spare keys into all departments except outpatient pharmacy and specialist clinic shall be kept securely by the Security Unit.

3.9 Boards of Visitors

3.9.1 Hospital Board of Visitors

i. Membership

The hospital shall have a board of visitors (BOV) with not more than 20 members appointed by the Minister of Health for a period of 3 years.

ii. Function of the board of visitors

The board of visitors shall function in accordance with the Ministry of Health's guidelines. Refer to*: Surat Pekelliling Ketua Setiausaha KKM Bil. 3/2023 Pelantikan dan Peranan Ahli Lembaga Pelawat Hospital Kementerian Kesihatan Malaysia* dated 19 May 2023 and *Surat Pindaan Garis Panduan Pembukaan Akaun Bank Ahli Lembaga Pelawat Hospital dan Perbelanjaan Secara Berhemah bagi Peruntukan Kewangan yang Disalurkan* dated 6 April 2023.

iii. The BOV shall act as a link between the hospital and the community and contribute in various ways to the hospital's programmes such as hospital image, welfare programme, etc.

iv. Meetings shall be held at least thrice a year and maximum 6 times/year. Minutes of meetings shall be submitted to the Hospital Director, and copies forwarded to the State Director's office.

v. 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, intensive care units, medical store, etc. The hospital management shall take appropriate actions on the feedback received or issues raised by the Board. Reports of every visits need to be submitted to the hospital management.

vi. 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.

vii. Board members shall be invited to attend hospital functions and activities including the relevant Continuous Medical Education (CME) session.

viii. Board members shall be briefed on the hospital's "Patient and Family Rights" and their inputs are taken into consideration in drafting the policies.

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 must be female. The Board of Visitors shall consist of at least 3 female members.
iii. The board of visitors (BOV) shall function in accordance with the Ministry of Health's guidelines. Refer to: *(i) Mental Health Act 2001 (ii) Psychiatric and Mental Health Services Operational Policy MOH 2011* and (iii) *Pekeliling Ketua Setiausaha Bil 3/2011 Urusan Pelantikan dan Peranan Ahli Lembaga Pelawat Hospital Psikiatri, Kementerian Kesihatan Malaysia.*

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 manner.
iv. Refer to: *SPKPK Bil. 25/2021 Garispanduan Perkhidmatan Sukarela Di Fasiliti Kementerian Kesihatan Malaysia* dated 16 Disember 2021.

3.9.4 Registered Non-Governmental Organization

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

3.10 Public Relations and Media Management

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 identity;
- To coordinate the hospital's relations with the public through the news media.

3.10.2 Complaints and Feedback

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

ii. The appointed members of Hospital Complaint Management and Handling Committee and the Patient Safety and Management Review Committee 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 third party, and via telephone communication.
- Written Complaints are complaints received through *Sistem Pengurusan Aduan Awam* (SiSPAA), letters, faxes, e-mails, physical feedback forms from suggestion box or online forms that are accessible via QR code and others.
- Mass Media are complaints received through social media, 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 1 working day and replied within the specified period of receiving the complaint according to its complexity. Where possible, efforts shall be taken to contact the complainant.

vi. Investigation report shall be submitted to the relevant authority within 15 working days of receiving the complaint. Independent Inquiry report for medico-legal cases should be submitted to the State Health Director within 7 working days of the meeting.

vii. The subsequent management of complaints shall be carried out in accordance with *Garis Panduan Pengurusan Aduan Awam KKM versi 1/2018* and Guidelines on the Management of Medico Legal Complaints in the Ministry of Health, Medical Practice Division, Ministry of Health Malaysia, 2nd Edition 2019.

3.10.3 Suggestion Box / Feedback QR Code

Suggestion boxes and QR code for feedback shall be placed at strategic locations to get feedback and comments from the public. 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 subject to disciplinary action.
- Staff are not allowed to ventilate dissatisfaction or complaint on work in social media. All complaints should follow the proper channel of communication.
- Refer to: *(i) SPKPK Bil.13/2004 Mengenai Peraturan Membuat Kenyataan Kepada Media Massa Bercetak dan Elektronik serta Orang Ramai* dated 5 November 2004, *(ii) Polisi Larangan Membuat Penyataan Awam KKM 2021.*

3.10.5 Photography/Filming/Interviews

- As recordings made for clinical purposes constitute part of a patient's medical record, it should be treated in the same way as any other part of the medical record.
- Prior consent must be obtained if the practitioner is planning to take clinical photographs or make audio-visual/multimedia recordings.

- 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 without approval.
- Permission for the privilege of photographing a patient in the hospital may be given if comply to the two of the followings:
    a) In the opinion of the doctor in charge of the case, the patient's condition will not be jeopardized.
    b) 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

- Hospital shall organize talks or exhibition to provide health education to the public.
- Health promotional activities shall also be organized to create public awareness and encourage public participation.

3.11 Cluster Hospital Initiative

i. Cluster Hospital Initiative by Ministry of Health involves collaboration of several hospitals located within the same state and in a nearby geographical area where these hospitals are aligned in terms of service and patient flow.

ii. A cluster hospital will provide specialist services to all patients who are within the network coverage of all the hospitals involved and all human resources, facilities, and other facilities are shared between these hospitals.

iii. In the planning and operation of a cluster hospital, the philosophy and guiding principles that shall be applied are:

- Cluster wide approach: Clinical governance and leadership shall be evidence-based and holistic.
- Safety and quality: Service redesign and reconfiguration must be firmly embedded in a culture that places priority in patient safety and quality service delivery.
- Appropriateness: The planning and provision of service must be appropriate and responsive to the needs of the local community. There should be adequate hospital-primary care-community interfaces with practice of consistent standards within the cluster with seamless transfers of acutely ill patients.
- Accessibility to care: The delivery of hospital services shall be close to patients' homes or within safe physical reach for all sections of the population.
- Rational resource allocation: Resource allocation must be based on the principle of resource sharing with proper matching to the services planned at the individual hospital within the cluster. This can be achieved through cost effective investment in services and appropriate technology, and transparent in selection of priorities.
- Workforce/manpower distribution: Ensure appropriate and fair distribution of manpower based on service needs and complexity. Efforts shall be made to ensure retention of professional talent in the cluster, allowing alignment of human competencies with service provision.
- Training and research: Training and research, particularly in the clinical areas, shall be given due priority.

iv. Cluster Management Committee (CMC) shall be formed to manage the operations and development of the hospitals within the cluster. The Hospital Director of the Lead Hospital shall be appointed as the Head of Cluster.

v. The clinical services provided by Sarawak Central Cluster Hospital shall be coordinated and supervised by the clinical head of departments in each hospital.

4. CLINICAL GOVERNANCE

i. Protocols and procedures shall be developed or adopted.

ii. All protocols & procedures developed or received should be communicated and made accessible to all relevant staff.

iii. All Heads of Department and managers shall ensure compliance to standard protocols & procedures.

iv. All Heads of Department concerned 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 rights 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. The medical care provided shall take into consideration the cultural, spiritual, and religious beliefs of the patient and family.

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

iv. 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.

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

vi. Application of physical restraints for patient shall comply with the Mental Health Regulation 2010 and Guideline on Management of Aggression in KKM Facility.

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

i. 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.

ii. A proper risk assessment shall be carried out on patient in the area of fall and risk for pressure sore so that appropriate care is instituted. Morse fall score assessment shall be carried out on all patients at least on daily basis. Appropriate turning of patient as per protocol shall be carried out on bedbound patients.

iii. Security measures shall be in place to ensure safety of patient vulnerable to physical injury or lost.

   a. There shall be strict control of visitors entering wards with children and infants by the security guard. Visiting hours and use of visitor pass must be strictly adhered to. Proper registering of visitors must be done at all times regardless of visiting hour. Proper record and checking of infants and children and their guardians must be done when they are discharged from the ward. No children or infant is allowed to leave the ward during visiting hours without verifying their status.

   b. CCTV placed at strategic points and psychiatric wards shall be monitored on a regular basis.

   c. In psychiatric ward, risk assessment of violence and suicide for patients shall be carried out routinely and regular patrol to identify abnormal behavior of patient shall be done to supplement the risk scoring.

   d. A patient shall be given caretaker and visitor passes on admission. A patient is allowed to have only one accompanying relative who holds the caretaker pass.

   e. During non-visiting hours, only those with visitor’s pass are allowed to enter the clinical blocks.

   f. In event of an impending death, a special pass will be issued to relatives and security guard at the entrance will be informed. Family members will be allowed entry and registration of their identities will be made.

4.1.4 Right to Adequate Information

i. A patient / family shall have access to all the services provided by the hospital.

ii. 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.

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

   a. The right to adequate and understandable information on prescribed and purchased medicines.

   b. The right to the most effective and safe medicines. Safety must be ensured by the manufacturers and by legislative control.

   c. The right to convenient access to medicines.

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

   a. The purpose of the medicine

   b. The possible side effects

   c. The avoidance of any food, alcoholic beverages or other drugs

   d. The duration necessary for any medication prescribed

   e. The measures to be taken if a dose is forgotten or if an overdose is taken.

v. A patient shall have the right to information on approximate cost of treatment prior to provision of care and itemized statement for all charges at the point of discharge and receipt for payment.

vi. A patient / family shall be informed of available financial or social welfare assistance.

vii. 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.

viii. 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.

ix. A patient and next-of-kin shall have the right to have the details of the patient's condition, investigations, diagnosis, treatment and alternative treatment if available, option to seek second opinion, discharge and follow up plan, and prognosis.

x. All communication and other records relating to the patient's care shall be treated as confidential, unless:

   a. authorised in writing by the patient

   b. 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.

   c. the information is required by due legal process.

xi. The hospital shall provide translator or interpreter to the best possible in the event patient has difficulty understanding the common language used.

xii. Upon decision of discharge, patient / family shall be informed of the discharge plan to ensure continuity of care.

xiii. A patient / family shall be properly counseled prior to be granted discharge at own risk and proper documentation made.

xiv. A patient / family shall have access to quality and performance improvement of the hospital.

4.1.5 Right to Appropriate Pain Management

i. A patient shall have access to appropriate management of pain as inpatient and outpatient. The pain score shall be less than 4.

ii. Patient requiring more complex management of pain shall be referred to pain clinic.

4.1.6 Rights to Privacy

i. A patient shall have the right to privacy during care and treatment.

ii. Examination of a female patient by a male doctor must be done in the presence of a chaperone, who is a medical personnel.

iii. When conducting intimate examination on a patient, the doctor should

   a. Explain to the patient the purpose of the examination and the process

   b. Ensure that the patient agree for the examination

   c. Always ensure that a chaperone is present

   d. Give privacy for the patient to dress or undress

   e. Keep the discussion relevant and avoid unnecessary comment

iv. Consent shall be obtained from patient and documented prior to photograph or participate in interview. Photograph of any parts of patients shall be strongly discouraged.

4.1.7 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.

4.1.8 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.

4.1.9 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.

4.1.10 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.

4.1.11 Patient's Possessions

i. Patient shall be informed of not bringing any valuable items to hospital.

ii. Patient / family shall be informed of not leaving belongings unattended.

iii. Hospital shall to the best possible provide a safe place for patient's belongings in the event patient needs to leave their belongings unattended due to medical treatment.

4.1.12 Provision Of Priority Lanes to Patients

Priority Lane at the registration counters maybe provided to the following clients:

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

4.1.13 Ward Orientation and Communication to the Patient and Family

i. <u>Ward orientation and briefing</u>

The patient/family shall be orientated on the facilities available in the ward e.g. toilet facilities, muslim prayer room, 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. <u>Informing patient's condition and prognosis</u>

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

iii. <u>Informing dangerously ill patient's condition</u>

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.

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.

4.1.14 Continuity Of Care

The hospital shall ensure there is continuity of care for patients discharged/ transferred from the hospital and interdisciplinary referral within hospital. (For details of policy on appointment / interdisciplinary referral / inter-facility referral, refer to 4.6)

4.1.15 Informed Consent

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

ii. In life-saving situation where a patient is unable to give consent and all efforts to trace relatives and next-of-kin have failed, a consensus of the primary surgeon/physician and a second registered practitioner shall be obtained. The primary surgeon/physician shall document in the patient's case notes stating that the delay is likely to endanger the patient's life and sign the consent form. The second medical practitioner must co-sign the consent form. The consent and efforts made to trace the relatives/ next-of-kin shall be documented in the case notes.

iii. All consent must be taken by a registered medical officer or specialist performing the procedure using the consent/appropriate form. 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

Abbreviation must not be used in documentation on the consent form. Consent/ refuse forms available in the hospital are:

- *Keizinan Pembedahan/Prosedur* / Consent for Operation/Procedure - PER / CONSENT / 2016
- *Surat Akuan Discaj Atas Risiko Sendiri* – SPKPK Bil. 24/2021 Prosedur Mengenai Pesakit yang Ingin Discaj Dari Hospital Atas Risiko Sendiri dated 13 December 2021

- *Surat Akuan Tidak Setuju Rawatan / Prosedur* / Testimonial Letter of Refusal of Treatment/Procedure – PER / REFUSE / 2016
- *Borang Keizinan Fotografi/Multimedia* / Photography/Multimedia Consent Form – PER / PHOTO / 2016 (for clinical/educational purposes)

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

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

vi. 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; or

(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.

vii. 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)

viii. The validity of consent for operation/procedure:

- Informed consent remains valid, allowing advanced consent to be sought, unless the patient's condition has changed. Should there be a change in the nature and clinical course and presentation of the illness for which the consent had initially been obtained, then a new consent must be obtained from the patient.
- A fresh consent is also needed when new information concerning the proposed intervention or alternative treatments have come to light in the intervening period.
- In instance when a patient from whom consent had been taken for a particular procedure, and the procedure is delayed or postponed, including and especially when an in-patient is discharged home, a new consent has to be taken as the circumstances or the disease condition may have changed during that period or the patient may not remember the details of the consent.

ix. Consent for patient receiving long-term transfusion support e.g. thalassaemia is valid for one year. Refer to National Transfusion Practice Guideline 2016, clause 7.2.4.

x. 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.

xi. Refer to MMC Guideline: Consent for Treatment of Patients by Registered Medical Practitioners 2016.

4.1.16 Responsibilities Of Patient and Family

Patient and his/her family members have the responsibilities to:

i. Provide information

Patients and families, as appropriate, must provide to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to their health. Patients and their families must report perceived risks in their care and unexpected changes in their condition. They can help hospital understand their status by providing feedback about service needs and expectations.

ii. Ask questions

Patients and families, as appropriate, must ask questions when they do not understand their care, treatment, and services or what they are expected to do.

iii. Follow instructions

Patients and their families must follow the care, treatment, and services plan developed. They should express any concern about their abilities to follow the proposed care plan or course of care, treatment, and services. The organization makes every effort to adapt the plan to the specific needs and limitations of the patients. When such adaptations to the care, treatment, and services plan are not recommended, patients and their families are informed of the consequences of the care, treatment and services alternatives and not following the proposed course.

iv. Accept consequences

Patients and their families are responsible for the outcomes if they do not follow the care, treatment, and services plan proposed or provided by the hospital.

v. Follow rules and regulations

Patients and their families must follow hospital's rules and regulations.

vi. Show respect and consideration

Patients and their families must be considerate of Sibu Hospital's staff and property, as well as other patients and their properties.

vii. Meet financial commitments

Patients and their families should promptly meet any financial obligation agreed to with Ministry of Health.

4.1.17 Research (Refer to 4.24)

4.1.18 Organ, Tissue, Cell Donation & Transplant Policy (Refer to 4.20)

4.1.19 Withholding And Withdrawal Of Life Support Therapy (Refer to 4.21)

4.1.20 Policy On Suspected Child Abuse And Neglect (Refer to 4.18)

4.2 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 aged 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.

4.3 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. 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.

iv. First time defaulters to specialist clinic will be given re-appointment date on presentation. Medications will need to be prescribed by doctors from health clinics, or Emergency and Trauma Department (ETD) for those who are from outside Sibu based on the previous prescription or last hospital admission. The patients shall be advised to visit health clinics or ETD if there is any change in medical condition prior to the re-appointment date.

v. Those who default specialist clinic appointment 2 times consecutively will be deemed discharging themselves from the specialist clinic.

vi. No by-proxy case is allowed for consultation appointment.

4.4 REGISTRATION & ADMISSION

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

ii. Identification of newborn shall use mother's IC/passport/other ID number plus prefix "E" followed by sequence of delivery. For example, second baby born to a mother with IC number 800417035646 shall be identified as 800417035646 E/2.

iii. All newborns shall be registered and MRN given. All stillbirths (fresh/ macerated) shall be registered for clinical/ reporting/ costing (Casemix) reasons and MRN given.

iv. The staff at the registration counter shall be responsible for ensuring the completeness of the information and also to enter the data into *Sistem Maklumat Rekod Pesakit* (SMRP).

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

vi. For cases using false/fake identification, once known, the hospital staff shall ensure that a report was made to the relevant authority/police. Necessary documents including the correct identification card/passport, police report and *surat akuan sumpah* are required before amendment of the patient's information can be made.

4.4.1 General Patients

Patients shall be admitted through the admission counter to all wards during office hours. At other times, it shall be carried out by the Emergency and Trauma Department (ETD).

4.4.1.1 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 ETD after office hours

ii. Emergency cases may be transferred directly from the ETD 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.

4.4.1.2 Deposit and Guarantee Letter

Patients or their relatives shall pay a deposit or produce a guarantee letter on admission in accordance with the Fee (Medical) (Cost of Service) Order 2014; and Revised Circulars 'No. [44 dlm.KKM 203/20 Jld. 6] Panduan Perlaksanaan Perintah Fi [Perubatan] Pindaan 2003 – Caj Baru Bagi Pesakit Orang Asing'.

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

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

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

4.4.1.6 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.

4.4.2 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 E&T 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 7 days should be admitted unless reviewed or discussed and discharged by Emergency Physician or respective discipline's specialist.

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. Emergency & Trauma Department shall receive the case and stabilize the patients before referring to the managing teams.

vii. Admission of suicidal patient with or without known psychiatric illnesses Suicidal patient shall be admitted to relevant disciplines for treatment of acute presentation and the patient may or may not be admitted to psychiatric ward when condition stabilized pending decision of psychiatrist.

viii. Admission to Psychiatric Ward shall follow the procedures stated in Mental Health Act 2001 and Mental Health Regulation 2010.

4.4.3 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 Di antara 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.

4.4.4 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.

Mothers presented to Emergency & Trauma Department shall be received and appropriately examined first before being sent to the labour room.

4.4.5 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.

4.4.6 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.

4.4.7 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 and with availability of such service in the ward concerned.

ii. Decision to admit the patient to First Class shall be determined / verified 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.

4.4.8 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.

4.4.9 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.

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

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

4.5 DISCHARGE

4.5.1 Routine or Planned Discharge

i. The ward Medical Officer (MO) or Specialist shall decide when to discharge a patient from hospital. The House Officer (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 patients deemed fit for discharge shall be provided with a prescription and relevant information about their medication prior to discharge.

vii. All discharged patients must settle their bills in accordance with "the Fees [Medical] (Amendment) Order 2017 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.

4.5.2 Discharge And Transfer of Patient to Another Hospital

i. Only the specialist is authorized to discharge and transfer patients to another hospital.

ii. For transfer of patient for step-down care, the receiving hospital must be informed prior to transfer and a formal letter containing information on patient condition and plan of management to be given along with the patient. Arrangement for transfer is preferred to be done when receiving hospital is transferring a patient to Sibu Hospital. The escort staff from the receiving hospital will escort the patient back. However, prior arrangement must be made with the receiving hospital. In the event it is decided for Sibu Hospital transport to sent patient to receiving hospital, patient is to be escorted by Sibu Hospital staff.

4.5.3 Discharged At Own Risk (AOR)

i. All patients requesting to be discharged against medical advice can do so after obtaining adequate explanation and clarification from the medical officer in charge unless not in compliance to the Prevention and Control of Infectious Diseases Act 1988 (Act 342), Mental Health Act (Act 615), and Child Act 2001 Amended 2016 (Act 611).

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, adequate medication supply, follow up appointment and further management e.g. discharge notes, medical certificate, appointment card etc.

iv. Refer to: SPKPK Bil.24/2021*, Prosedur Mengenai Pesakit Yang Ingin Discaj dari Hospital Atas Risiko Sendiri* dated 13 December 2021.

4.5.4 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, hospital security must be alerted, and 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.

iv. Patient who attempts to abscond but managed to be found within the hospital compound and brought back to the ward shall be closely monitored by the ward staff or security guard. Assessment should be made to ascertain the reason for absconding, with psychiatry input obtained and suicidal / aggressive precaution implemented if needed. The patient may be allowed to be discharged against medical advice if he / she is still keen to leave the hospital after counselling, provided it is not against the law, as stated in 4.5.3 (i).

4.6 REFERRALS

4.6.1 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. Referral shall preferably be executed by either medical officer or specialist (e.g. medical officer to medical officer or specialist to specialist). However, the receiving specialist must be notified of all referred cases after initial assessment by his/her medical officer.

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 another 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 is to be performed by the nursing team of the respective wards.

d. If the patient is for discharge, the O&G team shall be informed to ensure proper discharge plan is 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 MO 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.

4.6.2 Referral of Non-inpatient within hospital

i. Non-inpatient present within hospital with medical needs, excluding postnatal mother rooming in with child, shall be advised to obtain treatment at Emergency and Trauma Department except in the event of emergency.

ii. Postnatal mother rooming in with child, in the event of medical needs within the postpartum period, shall be referred to O&G who will serve as the primary team.

iii. Case with suspected psychiatric problem or with behavior of potential harm shall be informed to the security team to facilitate sending of concerned individual to Emergency and Trauma Department.

4.6.3 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 the receiving 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 State Health Department before proceeding 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. House Officer is not allowed to escort case. The staff who escorts the case should know the condition and management of the patient.

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 detailed history of the patient and the 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 and Trauma 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 and Trauma 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 *SPKPK Bil. 2/2009 Garis Panduan Rujukan dan Perpindahan Pesakit di antara Hospital-hospital KKM* dated May 2009.

4.7 DEATH

4.7.1 Death at Hospital

i. The doctor in the ward or the Emergency and Trauma Department shall carry out confirmation of death. The fully registered medical practitioner, on confirming death of patient, shall register the death using Form VIII Medical Certificate of Death (BD9/68) if forensic post-mortem examination is not required. House Officer is not allowed to sign the above document.

ii. On confirming death, the ward/departmental staff shall verify the deceased status as organ donor, notify the mortuary and the next-of-kin and conduct the last office. If the next-of-kin is not available, he or she 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. Body of the deceased must be tagged with a body tag bearing the identity of the deceased, a white tag for non-police cases (not requiring autopsy) and a red tag for police cases (requiring autopsy).

v. 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.

vi. In the case of referred patient, the referring hospital shall be responsible for the transfer back of the dead body in the event of the patient passed away during transfer to the referred government hospital which is accessible by road.

vii. Unclaimed bodies (non-medico legal 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.

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

ix. 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.

x. Existing guidelines such as Policies and Procedures on Infection Prevention and Control, Ministry of Health Malaysia Third Edition 2018 shall be complied with.

xi. Unclaimed bodies shall be handed to the local medical faculties for the purpose of education and research if they fulfilled the criteria and all the procedures are followed.

xii. 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*.

4.7.2 Brought 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 and Trauma Department and a police report shall be made before transferring the body to Mortuary.

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

4.7.3 Post-Mortem

i. When the cause of death could not be determined, a clinical post-mortem may be 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.

4.8 PATIENT RELATED POLICIES IN THE WARD

4.8.1 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 and bed management unit.

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 be based 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 half an 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.

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 (BHT)

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 and related circulars produced by the Ministry of Health and Jabatan Kesihatan Negeri Sarawak 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.

The relatives are allowed to bring food and drinks for the patients provided there is no contraindication & there is no special order from doctors.

Staff shall enquire from patients who are not on special diet whether they will take hospital meal before pressing order. This is to avoid food wastage.

vii. Notifiable diseases

All notifiable diseases shall be notified to the Divisional Health Office via CDCIS e-Notifikasi or phone in accordance with the Prevention and Control of Infectious Diseases Act 1988.

viii. Review of outpatient in wards

Review of outpatients shall be done at the specialist clinic or Daycare except for the following cases:

a. Paediatric oncology patients
b. Psychiatric patients that discharged as home leave (prepare for fast-track admission if required)
c. Postnatal mother rooming in with their child who is admitted

ix. 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.

x. Patient under police custody

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

xi. 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.

xii. Emergency trolley

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

xiii. 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.

xiv. 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.

xv. Incident report

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

xvi. 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.

4.8.2 Patient Identification and Use of Wristband

i. All patients nursed in Red Zone, Yellow Zone and Observation ward of Emergency and Trauma Department must be given identity wristband.

ii. All inpatients must wear identity wristband.

ii. Use of two (2) identifiers shall be practiced by all hospital staff at all times for all procedures.

iii. Refer to Malaysian Patient Safety Goals 2.0 year 2021 and Patient Identification Manual Ministry of Health year 2013.

iv. Patient's Drug and Food Allergy history must be assessed and taken upon admission. Red tag must be instituted in patient's wristband once allergy status is identified.

v. Patient who is involved in clinical trial should also be identified upon admission and informed to Clinical Research Centre immediately.

4.8.3 Investigation Orders (Laboratory and Imaging)

i. Ordering of investigations

All investigations shall be ordered and endorsed by doctors. Certain laboratory and diagnostic imaging requests must be made through specific online systems. All specialized imaging investigations such as ultrasound, CT and MRI and specialized laboratory test requests need to be endorsed by specialist. Informed consent shall be taken as required.

ii. Taking, labeling and dispatching of specimens

Blood specimens are to be taken by nurses or doctors. Specimens shall be labeled by ward staff clearly with legible handwriting. Biological specimens (blood, urine, sputum, etc.) shall be dispatched to laboratory by porter service. However, urgent specimens shall be dispatched by ward attendant immediately.

All surgical 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.

4.8.4 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.

Controlled antibiotics require countersign by authorized specialists in the department and completion of antibiotic request form and 72 hours antibiotic review form.

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.

4.8.5 Diagnostic and Therapeutic Procedures

i. Consent (Refer to 4.1.15)

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 or privileged for procedures requiring privileging.

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

4.8.6 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 appropriate consent form prior to procedure or surgery. Refer to 4.1.15 '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 shall be recorded using a prepared format and attached to the patient's case notes. Documentation should include the name of the surgeon and assistants, post operative diagnosis, description of the surgical procedure and findings, any surgical specimen sent and post operative care plan.

vi. Refer to (i) *SPKPK 23/2009 Pelaksanaan Inisiatif Keselamatan Pesakit*: Safe Surgery Saves Lives dated 12 November 2009, (ii) *SPKPK Bil.4/2018 Penambahbaikan Pelaksanaan* Safe Surgery Saves Lives Programme *di Hospital dan Institusi Perubatan KKM* dated 20 September 2018, (iii) Anaesthetic Clinic Protocols, 2012.

4.8.7 Patient Movement

i. General Patients.

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

ii. Critically ill patient

- Transfer of critically ill patient to another center should be escorted by a medical doctor who is competent to handle any unexpected event, with the assistance of a competent staff nurse if necessary. The hospital shall provide ambulance service for inter-facility transfer of patient.
- Inter-departmental transfer of critically ill patient should be escorted by a medical doctor and assisted by nurses / assistant medical officers.

iii. Deceased

The mortuary attendant shall transfer any patient who dies in the hospital on a cadaver trolley to the mortuary.

4.9 INFECTION CONTROL

The hospital adopts the various recommendations set out in the third 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.

4.9.1 The Hospital Infection & Antibiotic Control Committee

Roles of Hospital Infection and Antibiotic Control Committee

1. The Hospital Infection and Antibiotic Control Committee (HIACC) is responsible in developing policies and procedures related to infection control, antimicrobial resistance and antibiotic usage in the hospital.
2. The HIACC is a source of expertise on matters relating to infection control and antibiotic usage.
3. The HIACC assists in drawing up plans, policy development and management of large outbreaks according to the major outbreak policy.
4. The HIACC assists in the planning and development of services and facilities in the hospital on issues that are relevant to infection control and antibiotic usage.
5. The HIACC advises the Hospital Director on technical matters related to infection control in the hospital.
6. 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).

4.9.2 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 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 intensive care units, which are particularly vulnerable to 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**

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 and related issues in infection control.
4. Participate and coordinate infection control-related educational campaigns.

vi. **Research and Quality Improvement Activities**

1. Participate with the microbiologists and appropriate clinical staff on research projects that are related to hospital infection.
2. Perform clinical audit/quality improvement projects on infection control activities and evaluate its effectiveness.

4.9.3 General Isolation Policies and Procedures

i. 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).

ii. Infectious patients shall be placed and nursed in single rooms wherever possible. The use of multi-bedded rooms for the same type of infection is acceptable.

iii. Staff shall be instructed to adhere to barrier nursing and standard precaution guidelines all the times. This includes frequent hand hygiene and the use of personal protective equipment (PPE) by those having direct contact with an infectious patient.

iv. All instruments and linen used by infectious patients shall be placed in special bags (without washing or soaking).

v. All clinical waste from infectious patients shall be double-bagged in yellow plastic bags for disposal by incineration. Management of the clinical waste shall be as stipulated in the privatisation contract.

vi. Refer to: Infection Control Unit Sibu Hospital Operational Policy.

4.10 MANAGEMENT OF MEDICAL RECORDS AND REPORTS

4.10.1 Documentation of Clinical Care

i. Every patient receiving care in the hospital shall have individual medical record.

ii. Only medical personnel are allowed to make entries in patient's medical record.

iii. 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 medical personnel.

iv. Documentation of medical notes shall contain sufficient information to identify patient, support diagnosis and treatment, document allergies and course and outcome of treatment and information for continuity of care. Explanation given to patient & family members shall be documented. Use of abbreviation is not encouraged and if needed, only approved abbreviations shall be used. Medical personnel should ensure that their handwritings are legible.

v. All documentation of procedures shall be completed upon completion of procedures.

vi. All documents related to patient management including laboratory results, diagnostic imaging reports, referral letters, nursing care plan, observation charts etc shall be compiled along with the case notes and kept current.

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

viii. Only registered doctors are allowed to prepare and sign the death certificate, certificate for sick leave, PER-PD301 form, discharge summary, consent form and all other forms with legal implications.

ix. All amendments made must be clearly cancelled and initialled by the respective medical personnel with date and time of amendment done. Entries shall not be deleted by corrective fluid.

x. Discharge note must be completed according to the format available and given to the patient or next-of-kin upon discharge. Discharge summary must be prepared by medical officers after the patient is discharged within 72 hours and filed in the patient's medical record.

xi. All records shall be indexed and coded within one month of the patient's discharge.

xii. Management of Patient Medical Record shall be in accordance to *Surat Pekeliling Ketua Pengarah Kesihatan Bil 5/2023 Garis Panduan Pengendalian dan Pengurusan Rekod Perubatan Pesakit di Fasiliti Kementerian Kesihatan Malaysia* dated 14 February 2023.

4.10.2 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 specified cabinet/room/bag except for current used records.

iii. All medical records for potentially medico-legal cases shall be kept locked in the 'Bilik Kebal'. 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 wards' Nursing Sisters.

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

vi. In the event where medical record is lost, a police report shall be made by the person responsible immediately.

vii. All patients' medical records should be transported in a locked bag and the person holding the bag shall not have access or 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. All the movement of medical records shall be kept and updated to allow tracking of records.

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

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

xiii. Access to Medical Record Unit shall be restricted and limited to hospital personnel who handle records.

4.10.3 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 & 25 years for 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.

4.10.4 Records for Specialist Clinics

The One Stop Counter holds its own record for outpatients (specialist clinics) except psychiatric and ophthalmology clinics. Active records are stored at the One Stop Counter. Passive records are stored up to seven years at the supplementary store.

A copy of the discharge summary shall be kept in the respective outpatient medical record if the patient has subsequent specialist clinic follow up. This is to ensure continuity of care.

The Medical Records Department holds all inpatient records.

4.10.5 Medico-legal Emergency and Trauma Department records

Emergency and Trauma Department records classified under Medico-legal purposes are sent to Medical Records Department on monthly basis.

4.10.6 Dispatch of medical records

Health 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.

4.10.7 Storage of medical records

Active medical records shall be stored at the primary store at the Medical Record Unit.

Inactive medical records shall be stored at the designated storage areas outside Medical Record Unit.

Medical records for patients involved in Industry Sponsored Research are kept at Clinical Research Centre from the point of study completion.

Security and safety including proper pest control and fire safety of all the storage areas shall be ensured. A system shall be established to facilitate fast retrieval of medical record.

A medical record committee shall be established to coordinate all issues pertaining to medical record services.

4.10.8 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.

Information about patient can be released to authorized body without consent of patient or relatives.

4.10.9 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 preferably in the respective discipline involved in the care. The report shall be prepared within 4 weeks, starting from the time of patient's request to time of completion.

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 (Amendment) 2017 or in accordance to the Ministries circulars. The charge is based on the complexity of report and range between RM40 – RM1000 for citizens.

vi. Preparation of Medical Report should be in accordance to *"Pekeliling KPK Bil. 16/2010: Garispanduan Penyediaan Laporan Perubatan di Hospital-Hospital dan Institusi Perubatan"*.

4.10.10 Medical Statistics

i. Data and statistics to be collected and updated shall include the followings:

(a) number of admissions and discharges;

(b) bed occupancy;

(c) percentage of critical beds occupied;

(d) patient days;

(e) births and deaths;

(f) procedures performed;

(g) diagnosis in accordance to current ICD (International Classification of Diseases);

(h) length of stay in days;

(i) autopsies;

(j) number of new registrations;

(k) number of follow up

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

iii. Data and statistics on workload shall be made available to respective department or unit for planning purposes.

iv. Request for medical data and statistics of the hospital by non-hospital personnel shall be done through the medical record unit and release is subjected to approval of Hospital Director or higher authority as per MOH guideline.

4.10.11 Medical Board

i. Medical Board is established under **eight (8)** circumstances, according to *Buku Garis Panduan Penubuhan Lembaga Perubatan Di Fasiliti Kementerian Kesihatan Malaysia* published 2017 page 5 and 6.

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 Lampiran B (P.P. 10/1995), sent in together with the required documents. Application for other circumstances than those in *Garispanduan Penubuhan Lembaga Perubatan* 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 four copies; three copies to be sent to State Health Office and one copy to be kept in the respective hospital. The report shall be ready within 60 working days from the application date.

vi. The application for Medical Board shall be charged in accordance to the Fees Act 1982. Refer to: *"Surat Pekeliling Ketua Pengarah Kesihatan Bil.13/2017 Garispanduan Penubuhan Lembaga Perubatan di Fasiliti Kementerian Kesihatan Malaysia".*

4.11 DRUGS AND MEDICATIONS

4.11.1 Usage

i. Hospital Drug Formulary shall be revised at least once annually in Hospital Drug & Therapeutics Committee Meeting and used as a guide for drug prescription.

ii. Prescription and supply of drugs not listed in Hospital Drug Formulary but available in MOH Drug Formulary (i.e. Quota Drugs) shall be discussed and subjected to approval by Hospital Quota Drug Committee. Application shall be made using designated form and submitted to Hospital Pharmacy. In cases of emergency, approval can be given by Hospital Director after recommendations by Head of Department and Chief Pharmacist. This is to ensure optimum and rational drug expenditure by the hospital. Details are to be referred to the Terms of Reference of the committee.

iii. Prescription and supply of drugs not listed in MOH Drug Formulary shall require Director General of Health's approval [i.e. Ubat Kelulusan Khas (UKK)]. The respective head of department shall be responsible for justifications of drug usage and cost implication. Application for approval shall be made using designated form and submitted through Hospital Pharmacy. Hospital Pharmacy undertakes to screen and support justified applications based on current status of budget allocated by Cawangan Farmasi & Logistik Negeri (CFLN) and rational use before submitting to Hospital Director for final comments. Details of processing are to be referred to guidelines prepared by Pharmaceutical Services Programme, MOH.

iv. Use of sample drugs is not allowed unless prior approval is granted by Director General of Health (for drugs outside MOH Drug Formulary) or Hospital Director (for drugs within MOH Drug Formulary). Respective department is responsible for storing and monitoring the stock of sample drugs.

v. Approval by Hospital Director is required prior to lending medications to private healthcare facilities during emergencies, crises and disasters.

4.11.2 Prescription

i. Doctors shall prescribe drugs only to registered patients.

ii. Corridor prescribing for hospital staff and immediate family members is allowed for acute cases only. Staff are encouraged to seek medical treatment in Hospital Safety & Health Clinic, whenever possible.

iii. Self-prescribing is not allowed.

iv. Verbal ordering of drugs is not allowed.

v. Maximum duration of prescription is one year for patients who are stable, blood results within normal range, no change in the drug dosage, and not on psychotrophic drugs. Refer to *Surat Makluman Tempoh Preskripsi Ubat Berikutan Norma Baharu Bagi Pandemik COVID-19* [Ruj. KKM.600-34/3/7 Jld. 3(22) dated 16 July 2020].

vi. Prescribing to foreigners is limited to 5 days only, except cases allowed as per Director General of Health's instructions. Refer to *Garis Panduan Pembekalan Ubat kepada Warga Asing di Fasili-fasiliti KKM 2017 Edisi 3* [Ruj. KKM.600-34/3/7(28) dated 30 May 2017].

vii. Prescribing of Category A or A* drugs by medical officers must have specialist's countersignature or remark of 'S/T Specialist's name' on the prescription. However, corridor prescription of Category A or A* drug(s) for acute case must be counter-signed by specialist first before dispensing can be made.

viii. In Emergency & Trauma Department, prescribing must be made by Primary Team and remark of 'S/B Discipline's name' should be written on the prescription form.

ix. Prescription must be written in generic names. Only trade names and abbreviations approved by Hospital Drug & Therapeutic Committee are allowed.

x. Prescribers are required to rectify incomplete prescriptions in Inpatient Pharmacy or Outpatient Pharmacy.

xi. Prescription referred by the Pharmacy Department from other Ministry of Health hospitals and clinics shall be accepted. Prescription from IJN for a registered MOH patient shall be accepted subject to availability of drugs.

xii. Prescription from the private sector shall not be accepted.

xiii. Prescription of partial supplies shall be filled at specified intervals. Patient shall be required to collect their medicines within one week of the date of prescription.

4.11.3 Dispensing

i. Prescriptions must be screened, transcribed, filled and dispensed as per updated operating procedures.

ii. Prescriptions are to be transcribed into Pharmacy Information System (PhIS). However, data entry must be made in accordance to updated operating procedures to ensure medication safety.

iii. Drugs shall be dispensed at designated pharmacy counter as per patient criteria determined at Screening Counter.

iv. Drug counselling shall be provided to individual patients based on needs and criteria set by MOH guidelines.

v. Bedside dispensing shall be carried out for discharged patients as best possible.

vi. Urgent needs after office hours shall be attended by pharmacy personnel on extended-hour duties (for inpatient supplies) or personnel of on-call duties (for CDR & TPN cases).

vii. All cytotoxic drug prescribing, dispensing and serving should comply to the "procedures on handling of cytotoxic drug".

viii. During office hours, discharge prescriptions are to be dispensed at Inpatient Pharmacy Discharge Counter and prescriptions from Specialist Clinics and Emergency and Trauma Department are dispensed at Outpatient Pharmacy. Ward supplies are prepared by Inpatient Pharmacy Units at respective floor in Clinical Block (Satellite Pharmacy).

ix. After office hours, all prescriptions and ward supplies are dispensed at Inpatient Pharmacy (5.30pm until 8.00am).

x. During weekends and public holidays, ward supplies and discharge prescriptions are dispensed at Inpatient Pharmacy.

xi. Value-Added Services (VAS) including Drive-thru pharmacy counter service are available for registered patients to ease collection of partial medication supplies and to reduce congestion at the Specialist Clinic Pharmacy.

4.11.4 Monitoring

i. Usage of drugs, prescribing & dispensing errors and adverse drug reactions shall be monitored by pharmacy department and Hospital Drug & Therapeutics Committee.

ii. Hospital Drug & Therapeutics Committee shall meet at least three times per year. Details are to be referred to Terms of Reference of the committee.

iii. Drug safety issues, awareness and preventive activities will be monitored and discussed in Hospital Medication Safety Committee.

4.11.5 Supply of Medications

4.11.5.1 In-patient medications

In-patient medications prescribed during office hours shall be supplied on unit-of-use and floor-stock systems.

4.11.5.2 Additional stock items

The pharmacy is to supply the wards and departments with additional stock items on an indent basis.

4.11.5.3 Emergency medications prescribed after office hours

For emergency medications prescribed after office hours and not available in ward, the stock is to be collected from Inpatient Pharmacy.

4.11.5.4 DD drug cupboard

The DD drug cupboard should be topped-up by the ward via indenting to the Stor Unit Bahan Psikotropik at Inpatient Pharmacy on every Tuesday and Friday. Details are to be referred to *Polisi Pengendalian Bahan Psikotropik Jabatan Farmasi* Hospital Sibu.

4.12 STERILISATION & DISINFECTION

4.12.1 The Central Sterile Supply Unit shall be overall responsible for the sterilization and disinfection services in the hospital.

4.12.2 Sterilization and disinfections of equipment and surgical items shall be carried out using the appropriate and accepted technique or method.

4.12.3 Staff involved in the sterilization process shall follow the standard procedures to ensure the sterility of the product.

4.12.4 Staff shall wear proper attire for safety protection against infection and other hazards.

4.12.5 The unit shall ensure that equipment are in good condition and develop plan for restoration and replacement of non-functioning equipment.

4.12.6 Sterilization of delicate equipment shall be carried out by trained staff using appropriate technique. Soft dressing shall be pre-packed and sterilized centrally.

4.12.7 For high-risk patient, such as known case of HIV/AIDS and hepatitis B, disposable sets shall be used.

4.12.8 Processing of single used items which are re-used must be strictly complied with the procedures.

4.13 QUALITY MANAGEMENT

4.13.1 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 department and unit in the hospital shall be responsible for the provision of quality and safe service.

iii. The department and units shall establish their own standards and indicators for monitoring quality.

iv. Appropriate documentation of safety and performance improvement activities is kept, and confidentiality of medical practitioners, staff and patients is preserved.

4.13.2 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.

4.13.3 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/Improvement studies
- Incident reporting
- Patient Satisfaction Survey
- Clients Charter
- Clinical audit
- Nursing audit
- Mortality and morbidity review
- EKSA
- Hospital Accreditation Certification, Annual Accreditation self-assessment and assessment by internal surveyor

iii. All activities on quality improvement shall adhere to existing MOH guidelines and procedures (e.g. Surat Pekeliling Ketua Pengarah Kesihatan Bil. 4/2023 Polisi

Mengenai Akreditasi di Fasiliti Dan Perkhidmatan Penjagaan Kesihatan dated 14 February 2023).

4.13.4 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.

4.14 TRAINING

4.14.1 Credentialing & Privileging

i. Credentialing and privileging processes shall be complied with.

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

iii. Staff privileging will be implemented based on the Hospital Clinical Privileging Manual.

iv. Staff requiring credentialing shall comply with the requirement and submit the application to the Credentialing Board at Ministry of Health level.

v. Refer to:

   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"

vi. All non-government medical practitioners practicing in the hospital as university lecturers, 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.

vii. Refer to (i) *Surat Pekeliling Ketua Pengarah Kesihatan Malaysia Bil. 11/2020 Garis Panduan Pemantapan Dan Penambahbaikan Tatacara Bayaran Bagi Pengambilan Pegawai Swasta Sama Ada Pakar Perubatan Atau Pegawai Perubatan Subject Matter Expert (SME) Untuk Berkhidmat Secara Sessional/Honorarium Di Hospital Dan Institusi Perubatan Kementerian Kesihatan Malaysia (KKM)* dated 22 December 2020, (ii) *Surat Kebenaran Kepada Pengamal Perubatan Bukan Dalam Perkhidmatan Awam Di Bawah Seksyen 34C Akta Perubatan 1971 (pindaan 2012)* dated 8 April 2021.

4.14.2 House Officers and Other Post-Basic / Graduate Training / Master Programme Training

i. The House Officer training should be guided by '*Buku Panduan Program Pegawai Perubatan Siswazah Edisi 2012'* and any latest revised guidelines and circulars from the ministry. The House Officers' Training Committee shall meet regularly to discuss matters pertaining to individual house officer or the training as a whole.

ii. The hospital shall only engage with IPTS with valid Memorandum of Agreement with MOH.

iii. The hospital shall meet regularly with IPTS that has placement of students in the hospital.

iv. The hospital is only involved with one post-basic training (i.e. Midwifery). The hospital shall meet with the nursing training college on a regular basis. The identified medical personnel are to facilitate the training of the students.

v. Doctors who would like to join parallel pathway training for specialty are to apply to *Bahagian Pengurusan Latihan* via eHLP. Refer to *Surat Penyelarasan Proses Permohonan Untuk Menjalani Latihan Kepakaran Parallel Pathway Bagi Pegawai Perubatan Di Kementerian Kesihatan Malaysia (KKM)* dated 27 October 2022.

4.14.3 Continuous Professional Development (CPD) Programme

i. The management shall develop a programme based on needs analysis for human resource development. The training programme shall include:

   a. orientation for all newly appointed staff

   b. lectures, clinical presentations and in-service training

   c. refresher courses

ii. All department and unit shall conduct training needs analysis and develop or suggest training programme pertaining to the needs of staff and services.

iii. The Hospital Training Committee shall develop and discuss the training plans, monitor training status of various categories of staff and monitor the execution of the training plans. There must be a yearly training calendar.

iv. The management shall ensure that the minimum requirement of training for all categories of staff is complied with. The point system for Continuous Professional Development shall be implemented for all categories of staff.

v. The organizers are encouraged to organize not just in-house courses but also zone-based and international conferences. The collaboration with other MOH hospital or external health-related organization is strongly encouraged.

vi. Databases of in-house and external training programmes organized and/or attended by each personnel must be maintained and updated.

vii. Refer to: (i) *Surat Pekeliling Ketua Pengarah Kesihatan Bil. 6/2016 Penambahbaikan dan Pemantapan Pelaksanaan Pembangunan Professional Berterusan* atau Continuing Profesional Development (CPD) – *Garis Panduan Pelaksanaan* dated 16 Mac 2016.

4.15 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 and promotion programmes in line with the current MOH policies.

4.16 ETHICS AND LAW

The hospital shall abide by the laws of the country, policies and guidelines of the Ministry of Health, medical ethics and relevant policies and guidelines of other Ministries. Legislations, regulations, policies and guidelines may be amended by the relevant authorities as and when necessary.

4.17 OCCUPATIONAL SAFETY AND HEALTH POLICY

- The hospital's occupational safety and health (OSH) policy aims to provide a healthy and safe working environment for all.
- Hospital management recognizes their OSH responsibilities and establishes OSH standards and ensures compliance.
- A trained Safety and Health Officer shall be appointed.
- The Hospital shall ensure all OSH issues are addressed.
- OSH matter shall be a permanent agenda in all departmental or unit meetings.
- OSH training that is tailored to local risks shall be conducted regularly for all new staff. Continuous training shall be provided regularly to existing staff.

4.17.1 Hospital OSH Committee

- To identify hazards, assess risks and then eliminate, minimise or control the hazard.
- To facilitate in providing any safety equipment required and ensures that safety procedures are followed. Hazards and safety issues shall be regularly discussed and followed up in the committee meeting.
- To provide supervision and training for staff/students on appropriate safety procedures.

4.17.2 Staff's Responsibility

- To assist OSH unit in identifying hazards and risks.
- To comply with OSH policies by following safety precautions during procedures and using Personal Protective Equipment (P.P.E.) equipment when required.

4.17.3 Incident Reports

- All safety incidents, including "near misses" should be reported using online Hazard Complaint Management System (HCMS) which is accessible via https://aplikasi.jknsarawak.moh.gov.my/hcms/.
- Hazard classification and risk assessment will be carried out to assist the hospital and the concession company to plan the rectification measures. Discussion between the hospital management, engineering unit, ward/unit managers and supervisors from the concession company shall be done at the hospital Validation Committee Meeting for pending matters.
- Anonymity on patients and providers involved shall be kept at all times.

4.17.4 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 OSH and 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, 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 patient is 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. He should 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/ occupational health 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 Occupational Health / Infection Control Unit

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

- To disseminate information throughout the hospital regarding the prevention and immediate management of sharps and needle stick incidents.
- To ensure timely and appropriate management of sharps and needle sticks incidents.

- To generate incident statistics relating to sharps and needle stick incidents, and investigate trends or specific incidents as appropriate.
- 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 support injured staff by counseling affected employees and by coordinating longer term follow-up as necessary.
- To provide all necessary treatment, blood tests or referrals as appropriate.

v. Employees

All staff have an individual responsibility to ensure that sharps are always handled safely, disposed correctly and safely. They 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 stick incidents / percutaneous exposures to the Occupational Health Unit.
- 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:
    - 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/recapped 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 quarters 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

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

d. Arrangements

All staff upon entry to the hospital should undergo full biohazard screening to rule out tuberculosis and blood borne diseases (Hepatitis B, C, VDRL and HIV). This should be under jurisdiction of occupational health unit / staff clinic.

4.17.5 Air borne Infection

Placement and handling of patient with air-borne infection shall comply with the infection control guideline.

Screening of TB among staff shall be done at least once in every two years.

4.17.6 Environmental Safety

- Essential lightings shall be provided in the hospital.
- The floors & walking pathways shall be even and clutter free.
- Staircases & emergency escape route shall be kept clear at all times.
- Warning signage should be displayed if the floor is wet or slippery.
- All rooms must be well ventilated.
- Fire and electrical safety standards must be complied at all times. Staff shall be adequately trained to ensure good compliance to safe practices and familiarization to the existing protocols.
- Adequate space provided to ensure safe and smooth work routines by the staff.
- Modification or provision of extra safety features, as far as practicable, to ensure safe movement and use of facilities by handicapped individuals.

4.17.7 Chemical & Cytotoxic Safety

a. Labels
Make sure all chemicals and cytotoxic drugs are correctly labeled in the workplace. Chemicals shall be properly segregated according to hazard class with clear signage.

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. All staff shall be familiar with the guidelines and protocol on managing spillage incidence.

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

f. Personal Protective Equipment (PPE)
Provide the necessary PPE as recommended by the manufacturer of the chemicals and cytotoxic drugs. Employee shall wear the PPE provided appropriately and look after it when not in use and report any PPE defects.

4.17.8 Radiation 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 three years. Radiology staff are entitled for radiation leave of not more than 14 days in the current year as stated in the General Order.

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 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.

4.18 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):

4.18.1 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

4.18.2 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, nurses, allied health professionals, police, and social welfare officer.

4.18.3 The functions of SCAN Committee are:

a. To serve as a multi-disciplinary referral team within the hospital

b. To assess the likelihood of abuse or neglect for referred cases

c. To provide coordination amongst the various agencies in case evaluation, management and reporting of child abuse cases

d. To develop and review hospital policies and procedures for the handling of suspected or actual cases of child abuse &/or neglect

e. To maintain a database on the cases handled by the team

f. To provide and organize echo training for the hospital and the community

g. To enhance community awareness on the prevention and reporting of SCAN cases

4.18.4 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).

4.18.5 Multi-Disciplinary Approach

Ensure all relevant departments (inclusive but not limited to Paediatrics, Obstetrics & Gynaecology, Psychiatry, Emergency & Trauma, all Surgical Disciplines, Forensic, Laboratory) 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:

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

4.18.6 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.

4.19 BREASTFEEDING POLICY

4.19.1 Sibu Hospital Breastfeeding Policy

All health staff must be aware of the written Sibu Hospital Breastfeeding Policy and able to inform the public on its implementation, i.e. all mothers are encouraged to exclusively breastfeed their infants for the first six months of life and to continue breastfeeding until the age of two years, with complementary foods to be introduced at the age of six months.

4.19.2 Training of Hospital Staff

All hospital staff involved in the care of mothers and infants shall be trained so that they have the skills to implement these policies.

4.19.3 Education On Breastfeeding for All Mothers

All pregnant women will be informed of the benefits and the management of breastfeeding.

4.19.4 Early Initiation of Breastfeeding

All babies will be placed in skin-to-skin contact with their mothers immediately following birth for one hour. Mothers will be encouraged to recognize when their babies are ready to breastfeed, help offered by staff if needed.

4.19.5 Showing Mother How to Breastfeed and Maintain Lactation

All mothers will be shown how to breastfeed and maintain lactation, even if they are separated from their infants because of medical reasons.

4.19.6 Exclusive Breastfeeding

No food or drinks other than breast milk are to be given to newborn babies 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.

4.19.7 Rooming-in for Breastfeeding Mothers

Rooming-in facilities will be provided in order to allow mothers and babies to remain together 24-hours a day, so that breastfeeding is not interrupted.

4.19.8 Breastfeeding On Demand

All mothers are encouraged to breastfeed according to need, unless medically contraindicated.

4.19.9 No Artificial Teats or Pacifiers Allowed

No artificial teats or pacifiers will be given to breastfeeding infants because they can cause nipple confusion.

4.19.10 Ongoing Help Through Breastfeeding Support Group

Mothers will be referred to local women support group on discharge and encouraged to freely seek help from the healthcare personnel in postnatal ward (Ward 5) at Sibu

Hospital (Tel: 084-343333 / 238888 Ext 6021) or the local Maternal & Child Health Clinics for ongoing support of breastfeeding.

4.19.11 Code of Ethics for Marketing of Infant Foods and Related Products

All hospital staff must adhere to the latest "Code of Ethics for the Marketing of Infant Foods and Related Products".

4.19.12 Mother Friendly Care

All women will be helped to feel competent, in control, supported during labour, and ready to interact with their babies through mother friendly care practices.

4.19.13 Mothers with HIV Infection

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

4.20 ORGAN, TISSUE, CELL DONATION & TRANSPLANT POLICY

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

4.20.2 The transplant shall be performed in accredited centre by accredited personnel.

4.20.3 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.

4.20.4 The Tissue Organ Procurement (TOP) Team in the hospital shall consists 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.

4.20.5 Refer to *Surat Pekeliling Ketua Pengarah Kesihatan Malaysia Bil. 5/2019 Pengukuhan Tadbir Urus Perkhidmatan Perolehan Organ dan Tisu Kementerian Kesihatan Malaysia* dated 19 June 2019.

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

4.20.7 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.

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

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

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

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

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

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

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

4.21 POLICY OF WITHHOLDING AND WITHDRAWAL OF LIFE SUPPORT THERAPY IN THE CRITICALLY ILL PATIENTS

4.21.1 Scope of Policy

a. This policy is directed to both adult patients who are critically ill and are treated by various means in critical care or intensive care units. It is also applicable for those who are receiving life support therapy in conventional wards due to a lack of intensive care beds.

b. This policy is not applicable for children and those who are undergoing palliative care in homes.

4.21.2 Principles of Withholding and Withdrawal of Life Support Therapy

a. Withholding or withdrawal of life support is the process by which various medical interventions are either withdrawn or withheld with the expectation that the patient will die of the underlying disease.

b. Palliation is the prevention or treatment of pain, dyspnea and other kinds of suffering and providing basic care for patient comfort and must be provided to all patients in whom withdrawal of life support is being considered.

c. The principles of withholding or withdrawal of life-support should be based on the basic principles of medical ethics. These are:

- Beneficience (to do good) - Preservation of life which is frequently tempered by the second principle.
- Relief of unbearable suffering – This covers distressing symptoms such as pain, distress caused by anxiety, etc.
- Non maleficence - “First do no harm”
- Autonomy – Patients have the right to informed choices in treatment and have the right to refuse or accept a given mode of treatment.
- Social justice - A concept of a just allocation of medical resources that it must be good for the majority in society. Allocating scarce and expensive resources like intensive care for potentially non-salvageable patients limits the amount that can be spent on potential survivors. Increasing medical costs also make some form of rationing inevitable. Intensive care is extremely expensive and economic considerations form part of the consideration in ethical discussion regarding intensive care management.
- Trustworthiness - to be truthful to the patients and family or surrogates as to the prognosis of their loved ones.

4.21.3 Categories of Patients to be Considered for Withdrawal of Care

a. A patient with imminent death

- A patient facing imminent death has an acute illness whose reversal or cure would be unprecedented and will certainly lead to death during the present hospitalization within hours or days, without a period of intervening improvement.

- This is a patient who is clearly not responding to therapy and is reasonably unlikely to survive with continued therapy.
- Futility will be determined by prolonged multiple organ system failure. Further intensive care management with four or more organ systems failure is futile as shown by most studies and reports.

b. A patient with terminal condition

- A patient with a terminal condition has a progressive, unrelenting terminal disease incompatible with survival longer than 3-6 months.
- Life support treatment should be provided to treat superimposed, reversible condition only with clear and achievable goals in mind.
- Cardiopulmonary resuscitation should not be instituted in such patients with terminal, irreversible illness whose death is expected and in whom resuscitation represents a violation of the right to die with dignity.

c. A patient with severe and irreversible condition impairing cognition and consciousness but death may not occur for many months

- This category includes patients with permanent vegetative state or severe dementia. Permanent vegetative state is usually diagnosed in patients with severe cerebral injury after a month of assessment for non-traumatic injury and three months following a traumatic injury.
- In many of these cases who are nursed in wards, the decision is often not to initiate CPR or other resuscitative measures in the event of a downturn in the patient's condition.

d. A competent patient who has stated his/her wish not to initiate or who has stated his/her wish to have life support withdrawn

- This will include patients who, when competent, have given clear wishes before the present episode of illness in the form of a written Advanced Medical Directive (AMD).
- The principle of patient autonomy requires that physicians respect the decision to forego life-sustaining treatment of a patient who possesses decision-making capacity.
- The medical team however, has to be very certain that this is indeed the case and in the case of doubt should disregard previous wishes.

e. A patient who is brain dead

- Brain death is now recognized as death in many countries including Malaysia and it is perfectly legitimate and legal to withdraw all forms of life support from such patients once a diagnosis is made.
- The diagnosis of brain death can only be made by two trained specialists, with at least three years of postgraduate clinical experience and trained in brain death assessment.

- Organ support is only continued when consent for organ procurement is needed.

4.21.4 Scoring systems

a. Recently, various scoring systems have gained increasing importance as decision-making aids. Among the multitude of predictors available, the best known is perhaps the APACHE (Acute Physiological and Chronic Health Evaluation) which is now available in version III. There are also others such as SAPS (Severe Acute Physiological Score), TISS (to indicate the number of interventions), Trauma scores and many more.

b. Regardless of the accuracy of these predictors of outcome, these can only aid decision-making. They should not replace conscientious medical decision-making taking other factors into account.

4.21.5 Quality of Life

a. Patients in intensive care who are unlikely to regain some form of meaningful life as we know it pose a particularly challenging problem.

b. Quality of life has to be taken in the context of other factors mentioned above as well as the possibility of further rehabilitation and family support.

c. Most intensivists have resisted managing such patients in the ICU as there is no meaning in prolonging the life of these individuals. At the same time, it will be an easier decision not to admit these patients to an intensive care unit rather than taking them out of one.

4.21.6 Steps in Decision-Making to Withdraw or Withhold Life- Support

4.21.6.1 Medical consensus

a. It is essential that the primary physician and the intensive care team have agreed on a consensus before any decision is taken. The primary physician in our context refers to the specialist or consultant under whose department the patient is admitted.

b. In certain cases, more than one primary team may be involved and it is essential to have the consensus of all the caregivers.

c. In the event of absence of medical consensus, active treatment is continued. A time limited trial of therapy with definite goals should be established and subsequent review of management plan.

4.21.6.2 Nursing consensus

a. Nurses play a key role in intensive care and are in continuous contact with patients and relatives.

b. The sense of sympathy for the patient is often stronger and it is essential that they also support the decision to withhold or withdraw therapy.

4.21.6.3 Communication with patient/family

a. In the unfortunately rare event that the patient is fully rational, awake and competent, the communication should be with the patient.

b. More often in the intensive care setting the discussion is with the relatives.

c. A clear and honest medical opinion should always be given to the family.

d. To avoid any seeming conflict of opinion, it is best that a family conference is organized to facilitate communication and discussion about the current condition, prognosis and care plan.

e. The physician orchestrating discussion with either the family or patient, must be someone who is involved in the active care of the patient. This key person must be someone who has been frequently communicating with the family and has a rapport with them. The critical care team shall take the lead if they are involved. If not, the primary physician shall conduct/facilitate the family conference.

f. This task should be done by a senior medical staff and should never be left to the most junior doctor in the unit.

g. In dealing with the family, they should not be rushed as the mental shift from hope and cure to accepting the inevitable will not occur quickly. All explanations should be kept as simple as possible (in a manner easily understood by lay persons).

h. Facilities for discussion such as a private counseling room must be made available and the designated staff should help them with any clarifications if needed.

i. The decision and processes taken must not be conflict with the laws of the country. Euthanasia or assisted suicide is unlawful in Malaysia.

j. The family should be given sufficient time to come to terms with the impending loss of their loved ones. They should be allowed to ventilate their feelings and be as often as possible with the patient.

k. Time limited goals should be established by the clinical team and this must be based on clinical judgment and best medical evidence. Families will usually agree to discontinuation of life support systems after a reasonable trial of therapy has demonstrated failure.

l. In the event of disagreement between the physician and the patient or family, the assistance of an individual consultant, spiritual adviser or a patient representative is often helpful to reach resolution amongst all parties.

m. An institutional committee such as Hospital Ethics Committee, chaired by Hospital Director, may be involved if disagreements are not resolvable.

4.21.7 Management Plan for Withdrawal of Life Support Therapy

a. A clear plan of management for withdrawal of life support therapy is important to ensure that the process occurs smoothly.

b. The plan should be reviewed with the patient/family, with an emphasis on maintenance of comfort for the patient.

c. There should be great sensitivity to cultural norms and dignity to the dying patient. There should be five main objectives for ensuring a good end of life care;

- Adequate pain relief and relief of any other distressing symptom such as dyspnoea.

- Avoidance of prolongation of dying.
- Active sense of control over events.
- Strengthen relationship among loved ones.
- Relief of "burden" amongst caregivers and the loved one.

d. The plan for withdrawal will generally have the following components:

- All life support must be continued until the patient and his family had enough time together.
- Ensure patient comfort with attention to pain control and other symptom control e.g. dyspnoea, thirst and hunger throughout the process of withdrawal.
- Relief of pain and discomfort. At this stage, most ICU patients are already receiving some form of sedation and analgesia. These drugs are continued, often at higher doses. Opioids are the most useful drugs for relieving pain in terminally or critically ill patients. Morphine is the most common opioid and there is no maximum dose when used in these situations. In patients who have not previously received opioids, it should be titrated and rapidly increased until symptoms of pain and dyspnoea are relieved. Benzodiazepines should be used to treat anxiety until during the dying process.
- Therapies or medications that do not provide a net positive contribution to the comfort of dying patients should be discontinued e.g. antibiotics, renal replacement therapy, radiological examinations, and blood transfusions.
- Removal of life sustaining therapy are removed in an escalating fashion after ensuring the patient is both pain free and free from any form of discomfort.
- Withdrawal of vasopressors may result in immediate death and therefore it should be carried out when the family is ready.

e. In the event where relatives wish for their loved ones to pass away at home, the caregivers may assist with the necessary arrangements for the patient to be transported home. This will depend on the local logistics and practices.

f. Discontinuation of mechanical ventilation is probably viewed as more problematic than withdrawal of other interventions. Discontinuing mechanical ventilation does not differ morally from forgoing dialysis or cardiopulmonary resuscitation.

- There are two strategies for the withdrawal of mechanical ventilation:
    i. Terminal weaning i.e. gradually reducing the ventilator rate, positive end-expiratory pressure, oxygen levels or tidal volume while leaving the endotracheal tube in place.
    ii. Terminal extubation after appropriate suctioning
- There is no significant difference in patient comfort between the two methods. However, the endotracheal tube should generally be left in place while ventilatory support is reduced for the patients with difficulty in clearing their secretions or protecting their airways.

- Regardless of the method, frequent assessment of the patient's comfort during and after withdrawal of the ventilator is most important. Intravenous opioids and benzodiazepines should be used liberally to relief dyspnoea and other discomfort.
- The alarms on the monitors should be disabled.
- The family should be allowed to be with the patient if they choose to. Allow for time to pray.
- The physician should be present to ensure the patient's and family's comfort during withdrawal of mechanical ventilation.

4.21.8 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.

4.21.9 Post Withdrawal Management

a. The attending nurse and doctor should express sympathy to the family.

b. The attending doctor to certify the death. The death should be communicated in plain language gently and emphatically.

c. The attending nurse should explain the process of releasing the dead body to the family.

d. An appointment can be arranged for family with primary physician to facilitate the grieving process.

e. The withdrawal of life support is an emotionally traumatic experience for the nursing staff and doctors caring for the patient. They should have opportunities to express their own pain and grief through informal or formal staff meetings.

4.21.10 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.

4.21.11 Medico-legal Implications

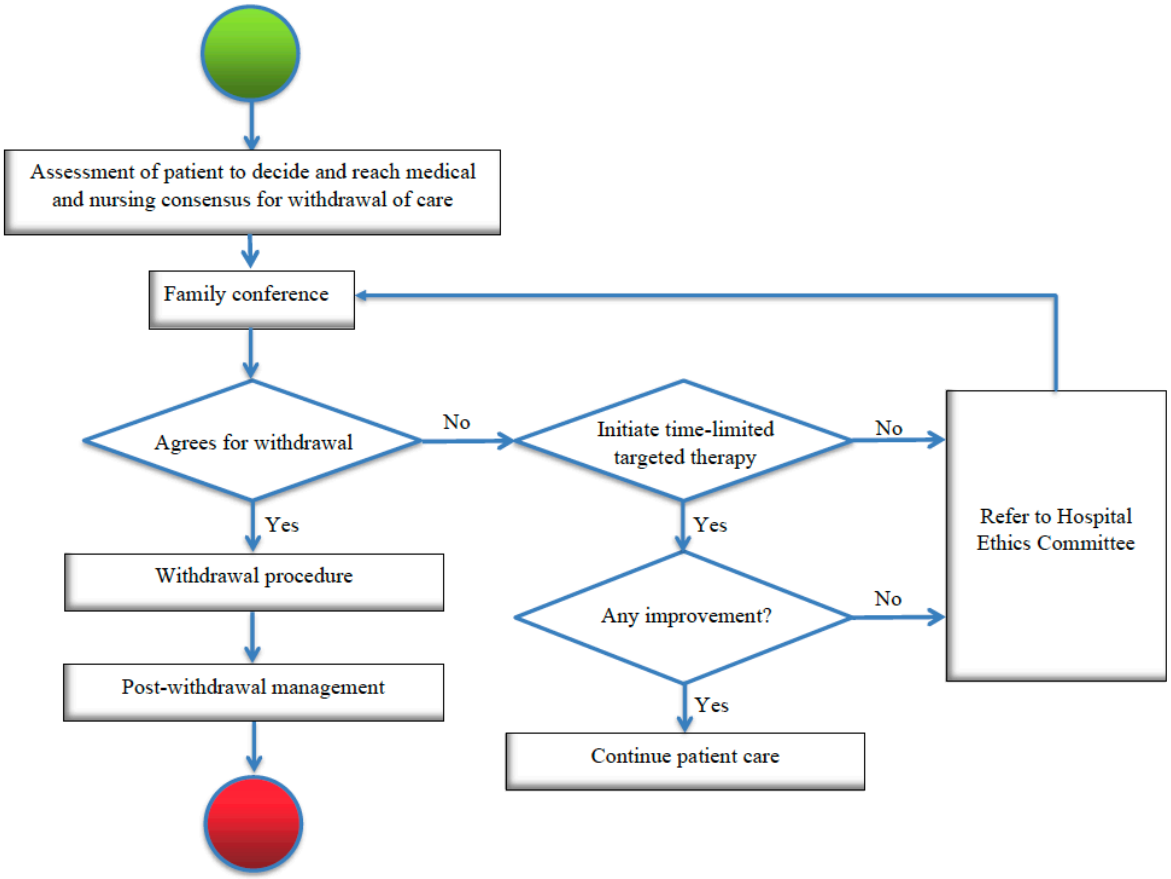
a. Withdrawal of life support is lawful at the patient's request at common law and in a few countries by legal statute.

b. It is more common to withdraw life support because the therapy is perceived to be of little benefit or not in the patient's best interests or the therapy is futile.

c. In Malaysia, there is very little case law and no legislation to direct the decision of whether to withdraw life sustaining therapy on grounds of futility or the patient's best interests although these are available in the UK and in the US.

d. The decision to withdraw therapy, usually places responsibility on the doctors in charge of the patient. Much weight is, however, placed on the wishes of the family or legal guardians.

WORKFLOW FOR WITHDRAWAL/WITHHOLDING LIFE SUPPORT



4.22 PAIN MANAGEMENT

4.22.1 Pain is assessed in all patients.

4.22.2 Healthcare provider should listen and respond promptly to patient's report of pain and manage pain appropriately.

4.22.3 Hospital staff should continually be educated and aware about pain assessment and management.

4.22.4 Standardized pain assessment tools must be applied consistently.

4.22.5 Pain is one of the vital signs.

4.22.6 Patient charter

4.22.6.1 This hospital will endeavour to provide you with a pain free experience.

4.22.6.2 We pledge to treat pain from all conditions including pain from acute medical conditions, surgery, trauma, cancer and labour.

4.22.6.3 Your pain will be given prompt attention and managed within one hour.

4.22.6.4 All patients with pain will be assessed and treated by trained professionals; for those with acute pain conditions, we aim to achieve pain score of less than 4.

4.22.6.5 Pain control will be individually tailored using appropriate medications as well as non-pharmacological methods including traditional and complementary medicine.

4.22.6.6 Our health care professionals will monitor your pain score and care for your comfort throughout your hospital stay.

4.23 MINIMALLY INVASIVE SURGERY

4.23.1 Introduction

Minimally invasive surgery (MIS) or Minimal Access Surgery (MAS) has proven to be advantageous in many surgical procedures. MIS is defined as a surgical technique which involves minimal trauma of access in performing the surgery. This is achieved by reducing the size of incisions to the minimal to access the site of surgical procedure and is usually done by putting trocars and ports at the incision sites. Surgery is achieved by means of long instruments inserted through these small ports.

The advantages of MIS include minimal post operative pain, excellent cosmetics, minimal post-operative adhesions, faster post operative recovery and excellent customer satisfaction. Despite its advantages, MIS may be associated with certain post operative complications and injuries, especially if the surgeon is not appropriately trained. The skills to perform MIS procedures are different from the open surgery skills considering the significant loss in visual and tactile feedback. These skills need to be specifically cultured and the learner may need special instructions and trainings to gain proficiency in these skills.

There is now a rapid worldwide adoption of MIS in view of the numerous advantages both to the hospitals and their clients. In order to develop and nurture MIS in Ministry of Health (MOH) hospitals, a hospital policy is essential to govern the various aspects in the implementation of MIS in MOH hospitals.

4.23.2 Promotion of MIS

The hospital shall undertake to encourage and promote MIS and shall:

i. Encourage various surgical departments to send their surgeons for training in MIS.

ii. Endeavour to support the training of surgeons in MIS in terms of financial support and granting of leave for surgeons to participate in training.

iii. Participate in all Ministry initiated programmes that promotes MIS.

4.23.3 Practice of MIS in hospital

i. All surgical departments shall ensure that MIS techniques are preferred for established MIS procedures.

ii. All patients shall be encouraged to opt for minimally invasive surgical techniques and appropriately informed on the benefits of MIS.

iii. All patients undergoing MIS procedures shall be appropriately counseled and consent shall be obtained correctly.

iv. All unsuitable patients shall be advised appropriately against MIS.

4.23.4 Encouraging day Care Surgery

All surgical departments shall take into consideration the advantages of MIS and shall encourage their surgeons to use minimally invasive techniques in their surgeries on day care basis.

4.23.5 Training in MIS

i. Hospital Sibu shall provide sufficient budget to actively support training of appropriate surgical trainees.

ii. All surgeons shall be given opportunity to learn MIS techniques and procedures.

4.23.6 Accreditation

i. All surgeons performing MIS procedures shall be appropriately trained, credentialed and privileged.

ii. Hospital Sibu shall scrutinise and monitor the performance of all surgeons performing MIS procedures.

4.23.7 Equipment

i. Hospital Sibu shall be adequately equipped with equipment and machines necessary for performing MIS procedures.

ii. Hospital Sibu shall ensure that all equipment and machines are in good working condition and maintained appropriately in accordance with the planned preventive maintenance (PPM) or maintenance by the supplier in required in the warranty period.

4.23.8 Safety/Audit/QA

The hospital shall ensure that

- All safety aspects necessary for the performance of any MIS procedures are performed in a safe manner and in accordance with the strictest standards.
- Audit is conducted to monitor surgical complications and adverse events.
- Quality Assurance Programs are in place to ensure favourable outcomes of MIS.

4.23.9 New or experimental procedures

All surgeons shall make necessary application for approval from the Privileging Committee of Hospital Sibu and satisfy all criteria.

4.24 RESEARCH

4.24.1 The hospital shall provide a conducive environment that will facilitate and support research activities.

4.24.2 Clinical research centre (CRC) of the hospital shall have a structural organization and facilities to provide governance, guidance and support for research activities.

4.24.3 All research shall require prior registration with the National Medical Research Register of the MOH (www.nmrr.gov.my), approval by the MOH, and if involving human subjects, require prior ethics review and approval by the Medical Research and Ethics Committee, Ministry of Health Malaysia. These research include:

a. Research conducted by staff of Hospital, or

b. Research conducted at Sibu Hospital by MOH or non-MOH staff, or

c. Research conducted on patients of Sibu Hospital, or

d. Research funded by MOH research grant

4.24.4 Information must be provided to patients and family about how to gain access to research, investigation or clinical trials relevant to their clinical needs.

4.24.5 The following information must be provided to patients when they are asked to participate in all clinical researches. These include:

a. the fact that it is a research

b. purpose of the research

c. probability for random assignment to treatment

d. research procedures to be followed, including invasive procedures and subject's responsibilities

e. experimental aspects of the research

f. description of foreseeable risks or discomforts

g. expected benefits – subject made aware if no intended clinical benefit

h. alternative procedure(s) / treatment(s) available and their potential benefits and risks

i. subject compensation in research-related injury

j. anticipated prorated payment, if any, to subject

k. anticipated expenses, if any, to subject

l. subject's participation in the research is voluntary-subject may withdraw at any time

m. direct access to subject's original medical records without violating confidentiality

n. records identifying the subject will be kept confidential

o. subject will be updated if new information becomes available

p. person(s) to contact for further information and in the event of research-related injury

q. circumstances for research termination

r. duration of participation in research

s. number of subjects involved in the research

4.24.6 Written informed consent must be obtained from patients and this shall be documented, dated before the patient participate in research, investigation or clinical trial.

4.24.7 All publications, whether in the form of research reports, journal articles or conference proceedings, arising of research as listed in 4.24.3, shall require prior review by the NIH, and subsequent approval by the Director General of Health.

4.24.8 All principle investigators and collaborators who wish to undertake interventional clinical trial research must acquire a Good Clinical Practice (GCP) certificate before being permitted to conduct trials.

4.24.9 The hospital shall tag and maintain medical records of patients involved in clinical trials including all relevant research documents. Management of records after expiry dates e.g. disposal/archiving shall be carried out in collaboration between the Medical Records Unit and CRC.

4.24.10 Refer to: (i) *SPKPK Bil.4/2011 Penyelidikan Klinikal dan Rangkaian Pusat Penyelidikan (CRC) di Hospital dan Penubuhan Jawatankuasa Penyelidikan Peringkat Negeri* dated 4 March 2011, (ii) *SPKPK Bil.9/2007 Garis Panduan Institut Kesihatan Negara Mengenai Penyelidikan yang Dijalankan di Institusi dan Fasiliti KKM* dated 5 September 2007.

5.0 RISK MANAGEMENT POLICY

5.1 Introduction

Sibu Hospital is committed in ensuring the safety of patients, staff and visitors to hospital. To this endeavour, this risk management policy is prepared to govern the formation of various risk management committee, the planning and implementation of activities and programme, various processes carried out in the hospital. The WHO patient safety resolutions, the Malaysian Patient Safety Goals and the Occupational Safety and Health Act serve as reference to the formulation of this policy.

5.2 Definitions

Adverse event or incident: An undesired outcome or occurrence, not expected within the normal course of care or treatment, disease process, condition of the patient, or delivery of services.

Failure mode and effects analysis (FMEA): A proactive method for evaluating a process to identify where and how it might fail and for assessing the relative impact of different failures in order to identify the parts of the process that are most in need of improvement.

Loss control/loss reduction: The minimization of the severity of losses through methods such as claims investigation and administration, early identification and management of events, and minimization of potential loss of reputation.

Near miss: An event or situation that could have resulted in an accident, injury, or illness but did not, either by chance or through timely intervention (e.g., a procedure almost performed on the wrong patient due to lapse in verification of patient identification but caught at the last minute by chance). Near misses are opportunities for learning and afford the chance to develop preventive strategies and actions. Near misses receive the same level of scrutiny as adverse events that result in actual injury.

Risk analysis: Determination of the causes, potential probability, and potential harm of an identified risk and alternatives for dealing with the risk. Examples of risk analysis techniques include failure mode and effects analysis, systems analysis, root-cause analysis, and tracking and trending of adverse events and near misses, among others.

Risk assessment: Activities undertaken in order to identify potential risks and unsafe conditions inherent in the organization or within targeted systems or processes.

Risk avoidance: Avoidance of engaging in practices or of hazards that expose the organization to liability.

Risk control: Treatment of risk using methods aimed at eliminating or lowering the probability of an adverse event (i.e., loss prevention) and eliminating, reducing, or minimizing harm to individuals and the financial severity of losses when they occur (i.e., loss reduction).

Risk financing: Analysis of the cost associated with quantifying risk and funding for it.

Risk identification: The process used to identify situations, policies, or practices that could result in the risk of patient harm and/or financial loss. Sources of information include proactive risk assessments, closed claims data, adverse event reports, past

accreditation or licensing surveys, medical records, clinical and risk management research, walk-through inspections, safety and quality improvement committee reports, insurance company claim reports, risk analysis methods such as failure mode and effects analysis and systems analysis, and informal communication with healthcare providers.

Risk management: Clinical and administrative activities undertaken to identify, evaluate, prevent, and control the risk of injury to patients, staff, visitors, volunteers, and others and to reduce the risk of loss to the organization itself. Activities include the process of making and carrying out decisions that will prevent or minimize clinical, business, and operational risks.

Root-cause analysis: A process for identifying the basic or causal factor(s) that underlie the occurrence or possible occurrence of an adverse event.

Sentinel event: Defined by the Joint Commission as an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse event.

5.3 Roles And Responsibilities

It is the roles and responsibilities of heads of department or unit to ensure compliance of the risk management policy. All shall demonstrate understanding and commitment to the integrated risk management system. The roles and responsibilities of the various parties are as follows:

5.3.1 Hospital Director

a. To establish and maintain a culture of risk awareness.
b. To ensure governance mechanisms effectively monitor risks and the way they are managed.
c. To set standards in compliance to the requirement of Ministry of Health and hospital accreditation body.
d. To ensure employees receive support in fulfilling their responsibilities.
e. To contribute towards attainment of goals and objectives set out by the Ministry of Health and the Malaysian Government in the five years strategic plan.

5.3.2 Medical & Dental Advisory Committee

a. To inform the Hospital Director on the identified risk or potential risk.
b. To advice the Hospital Director on the management of various identified risks and potential risks including the formulation of related policies.

5.3.3 Hospital Management

a. To be involved in formulating risk reduction strategy
b. To conduct proper risk financing.

c. To ensure there is enough resources in handling various risks and potential risks.

d. To ensure there is a proper system of communication of information pertaining to risk reduction strategy.

5.3.4 Risk Manager

The risk manager is the head of the Quality and Training Unit. The roles and responsibilities are as follows:

a. To liaise with the various secretaries of committees to ensure implementation of planned risk management activities.

b. To ensure regular reporting is done by various secretaries of committees.

c. To feedback to Hospital Director and the Hospital Management on a regular basis on any identified concern.

d. To notify Hospital Director immediately all the coded red adverse events, sentinel events or events with medico-legal implications that require immediate attention.

5.3.5 Various Risk Management and Audit Committees

There are a number of committees addressing various areas of concern and potential risk. The Hospital Environment and Safety Committee coordinates all the activities planned by various committees for environment and safety whereas the Patient Safety Management Review Committee addresses the various performance indicators, incident reporting and complaints. All these committee shall ensure that:

a. Risk assessment, risk analysis and audit are conducted on a regular basis.

b. Risk reduction, risk control and risk avoidance strategies are planned.

c. Implementation of activities under the risk reduction and risk control/prevention strategies or suggested remedial measures.

d. Evaluation of effectiveness of existing control and treatment of risk.

e. Training of auditors is done on a regular basis.

f. Briefing and training of staff on relevant risk are conducted and the targets set are achieved.

g. Report to the main committee or Hospital Director.

5.3.6 Employee

a. Actively support, report and contribute to the risk management process

b. Maintain an awareness of the risks and opportunities that relate to their work group.

5.4 Patient Safety

5.4.1 Awareness and Education

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

5.4.2 Best Practices In Healthcare

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

a. Hand hygiene: Clean care is safer care.
b. MOH Safe Surgery Checklist: Safe surgery saves lives
c. MOH Patient Safety Goals
d. GPSC: "Tracking Anti-microbial resistance"
e. Taxonomy for patient safety: Incident reporting & Incident classification for patient safety
f. Transfusion safety: MOH "Hemovigilance" program to monitor the adverse transfusion events
g. 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.

5.4.3 Evidence-Based Patient Safety Solutions

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

a. Proper managing concentrated injectable medicines
b. Assuring medication accuracy at transitions in care
c. Communication during patient care handovers
d. SOP to reduce the risk of patient harm resulting from falls
e. Ventilator associated pneumonia care bundle
f. Catheter related blood stream infection care bundle

5.5 General Management Of Risk

5.5.1 All levels of management in the hospital shall proactively identify hazards and potential hazards and the associated risk on a regular basis. Risk analysis shall be conducted and prioritization of the areas of concern shall be done using risk rating scale (Refer to Attachment A) for institution of risk reduction, risk control and risk prevention measures.

5.5.2 The concession company shall conduct risk assessment for the hospital structures and various systems in the hospital at least once per year and recommend risk reduction and risk control plan.

5.5.3 The concession company shall regularly submit the life cycle cost analysis (LCC) of medical equipment and non-medical equipment so as to allow proper planning of replacement.

5.5.4 Planned preventive maintenance of the facilities including equipment shall be carried out as scheduled and professionally to ensure patient and staff safety.

5.5.5 The managers of hospital and key personnel shall be educated on various risk assessment tools such as FMEA and Hazard Identification, Risk Analysis and Risk Control (HIRARC).

5.5.6 Various teams of the hospital shall carry out quality improvement activities on identified risks or issues and follow through the actions implemented.

5.5.7 There shall be regular review of various processes to ensure latest technology and practices are adopted to ensure safety of patients and staff.

5.5.8 There shall be in place a systematic monitoring and evaluation of the various risk control activities and preventive measures taken. Monitoring and evaluation report shall be submitted to the secretariat of the relevant committees on regular basis.

5.5.9 Hospital shall comply with the various policies on identified hazards and risk such as environmental safety and health policies, infection control policies, patient and family rights policies, security policies, case management policies for paediatric cases, pregnant mothers, mentally challenged patients and SCAN cases.

5.6 Management Of Adverse Events And Near Misses

5.6.1 All near misses, medical errors and adverse events must be reported in a timely manner using the latest available incident reporting system.

5.6.2 Event investigation should be initiated by the first responder and the designated Root Cause Analysis team in a timely manner and report submitted to Unit Quality.

5.6.3 Planned event analysis and evaluation of the root cause analysis should be carried out on a regular basis to ensure implementation of corrective or preventive measures are effective.

5.6.4 All event reporting, investigation and evaluation report should be properly kept either in digital or hard copy and remedial plan communicated to staff.

5.6.5 Confidentiality of personal information of staff or patients in event reporting shall be ensured.

5.7 Staff Competency

5.7.1 There shall be a planned staff professional development programme to ensure maintenance of appropriate level of competency among staff of various categories.

5.7.2 Hospital shall ensure that privileging and re-privileging of staff for identified procedures are being carried out as according to the required procedures.

5.7.3 There shall be regular skill assessment of clinical staff to ensure competency on core and privileged procedures.

5.7.4 There shall be planned targeted training on managing identified hazards and related risk control measures.

5.8 Revision And Compliance Of Procedures

5.8.1 Procedures should be reviewed and revised as appropriately or at least once in three years.

5.8.2 Revised procedures should be communicated to staff and training to be conducted as accordingly or if required.

5.8.3 Monitoring of compliance of procedures in terms of formal or informal audit should be conducted on a regular basis and feedback given to staff.

5.9 Complaint Management

5.9.1 Complaints, both internal and external, shall be managed in a timely manner and as according to the latest procedures to ensure loss control and minimisation.

5.9.2 Risks and potential risks identified shall be addressed and followed through.

5.9.3 Complainants shall be informed of the available compensation mechanism by the designated personnel.

5.10 Confidentiality and Release of Information

5.10.1 All patient information shall be kept confidential, and any release shall require consent from the concerned person unless in the event required by approved authorities.

5.10.2 All information pertaining to patient related incident reported shall be kept confidential.

5.10.3 Staff shall comply with the code of medical ethics when accessing patient information either from the medical records or the on-line results. Information shall be accessed with intention for patient management or for approved research purposes only.

5.10.4 Staff shall comply with all other hospital policies and procedures pertaining to handling of medical records.

5.11 Employee's Health

5.11.1 The hospital shall be maintained or upgraded as necessary to minimize occupational hazard to staff.

5.11.2 Infection control policy on placement and handling of infectious patients shall be best possible complied with at all times.

5.11.3 Staff working in high-risk areas shall have routine designated annual health screening.

5.11.4 Staff who are in high-risk categories and those who are more than 40 years of age shall have annual health screening.

5.11.5 Staff who are involved with hazardous materials or environment shall be educated on the risk of exposure and risk control strategy.

5.11.6 Staff working at high-risk areas shall be managed as according to guidelines considering exposure to occupational hazards.

5.12 Information Technology

5.12.1 Staff shall comply with the security requirement of the use of official website and internet network.

5.12.1 Information technology shall be used as a tool to further enhance the patient safety efforts.

5.13 Disaster Preparation And Management

Disaster encompasses both internal & external disasters. The internal disaster includes fire safety, patient collapse, security issue, diseases outbreak and flood.

5.13.1 Hospital shall have internal and external disaster preparedness plan which are periodically revised and tested.

5.13.2 Training of staff on necessary skills and updates on knowledge shall be regularly conducted by relevant committees.

5.13.3 Regular tabletop exercises and drills shall be carried out to ensure the preparedness of respective teams.

5.13.4 Details of disaster preparedness management are available in the respective disaster plan.

5.14 Training Centre

5.14.1 Students shall comply with the hospital rules and regulations and the code of conduct of students as stipulated in the Memorandum of Agreement with Ministry of Health.

5.14.2 Students shall perform procedures under the supervision of clinical instructors or tutors as not to cause harm to patients.

5.15 Public Relations

5.15.1 Hospital shall actively engage the Hospital Board of Visitor to inform the public on measures taken by hospital to reduce risk of patients or relatives during their hospital stay or visits.

5.15.2 Hospital shall maintain good working relationship with various government or non-government bodies.

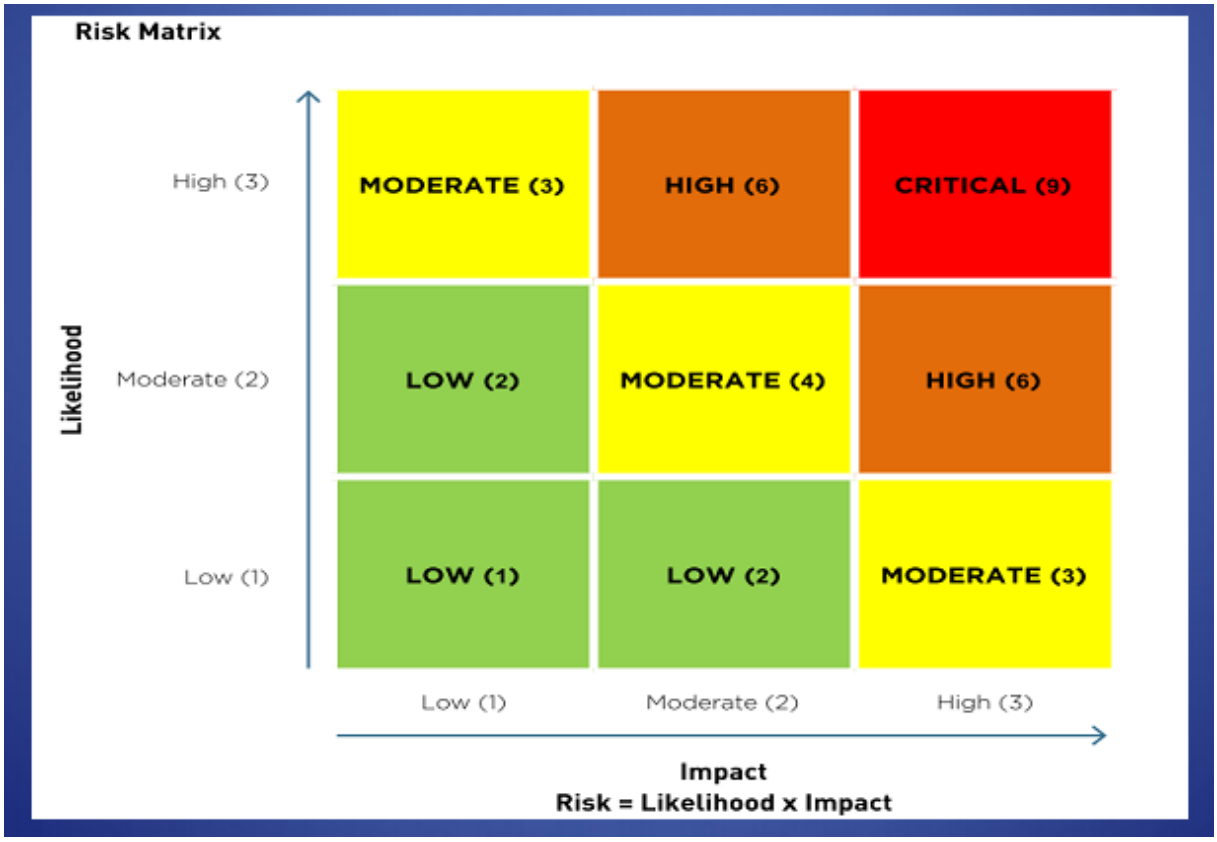
5.15.3 Hospital shall maintain transparency in handling various events of public interest and conduct risk communication as according to Ministry of Health guidelines.

5.16 Hospital Volunteers

5.16.1 Hospital encourages volunteers to help patients. However, the applications are subjected to approval of Hospital Director and they shall be obliged to comply with the hospital rules set for volunteers.

5.16.2 Hospital reserves the rights to withdraw the approval for the volunteer without prior notice in the event the volunteer is deemed to break the trust of hospital.

Attachment A



6.0 DISASTER MANAGEMENT

6.1 Disaster Plan

6.1.1 There shall be a management committee formed to manage specific emergency disaster that may arise, e.g. Fire Safety Committee. It is headed by the Hospital Director. The members of the committee shall include the clinicians, representative from the relevant departments/units and representatives from the privatized support services.

6.1.2 The committee shall be responsible for the preparation of the Disaster Management Plan, Hospital Contingency Plan, Business Continuity Plan and its implementation. Meetings shall be held regularly to discuss issues and remedial measures.

6.1.3 In the event of disaster, the Hospital Director shall declare alert and activate the disaster management plan.

6.1.4 Refer to: (i) *Panduan Pelan Tindakan Insiden Kecemasan dan Bencana Dalaman Bagi Hospital-Hospital Kementerian Kesihatan Malaysia* year 2019, (ii) *SPKPK Bil.12/2001 Pelan Tindakan Bencana Untuk Hospital-hospital di Bawah KKM* dated 4 December 2001.

6.2 Fire Safety

6.2.1 Fire Protection & Detection System and Fire Fighting Facilities

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

6.2.2 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 Officer or Unit Head concerned must be notified immediately should there be any impairment of the system.

6.2.3 Hospital Fire Safety Officer

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

6.2.4 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).

6.2.5 Training

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

The hospital's emergency response team shall be properly trained for firefighting and rescue.

6.2.6 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.

Staff shall be familiar with the evacuation plan, exit routes and the gathering sites. An exit route plan shall be displayed at strategic location in every department/unit/ward including the Assembly Areas.

6.2.7 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.

6.2.8 Refer to *Pelan Tindakan Kebakaran Hospital Sibu 2022*.

6.3 Hospital External Disaster Preparedness

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

6.4 Flood Preparedness

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

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

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

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

6.4.5 In the event of emergency, pick up transport shall be arranged with the assistance from the *Angkatan Pertahanan Awam Malaysia (APAM)*.

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

6.4.7 To refer to the Flood Preparedness Plan for details.

6.5 Disease Outbreak Preparedness Plan

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

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

6.6 Specific Contingency Plan

6.6.1 A specific contingency plan shall be made for the following situations:

- Power failure
- Lift breakdown
- Disruption in water supply
- IT system breakdown
- Air condition failure
- Tele-Communication Failure
- Gas leakage
- Air condition failure
- Building infestation
- Tele-communication failure (PABX shutdown)

6.6.2 The plan shall include notifications, allocation of responsibilities, immediate actions, alternative solutions and follow up measures.

6.6.3 All relevant staff shall be briefed on the plan.

7.0 HOSPITAL SUPPORT SERVICES

7.1 General

i. The following 6 support services are privatized in accordance to the specifications in the contract prepared by the Ministry,

- Facility Management
- Cleansing
- Linen and Laundry
- Healthcare Waste Management
- Biomedical Engineering
- Facility Engineering

ii. The hospital management with the assistance of the Hospital Engineer shall be responsible for the overall coordination of the 6 services. Liaison Officer (LO) for each service shall be appointed to monitor and coordinate all the activities and to ensure compliance to the Concession Agreement (CA), 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 Hospital Support Service 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 and the Concession Company staff.

iv. The validation committee meeting (VCM) shall be held monthly to discuss and decide on deductions for non-conformance.

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

7.2 Facility Management Services (FMS)

i. A competent Facility Manager shall be appointed to manage effectively and coordinate all the services provided by the Concession Company to the hospital.

ii. Services provided shall comply to statutory and regulatory requirement.

iii. There shall be adequate, qualified, competent and trained manpower provided according to norm to effectively deliver the management and operations of hospital support service.

iv. The Concession Company shall ensure that all outsourced activities and services are carried out by specialized / licensed contractors.

v. Technical report, technical advice and condition appraisal shall be provided within the set period according to the TRKPI and MAP.

vi. The Concession Company shall provide regular user training according to schedule.

7.3 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 attire 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.

7.4 Cleansing Services (CLS)

i. General cleaning of departments shall be done according to the agreed TRPI, MAP and HSIP.

ii. The 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.

iii. Cleansing shall be carried out according to the correct technique, equipment and using of appropriate detergent.

7.5 Healthcare Waste Management

i. Training of staff

Senior staff member shall be identified to train staff on how to handle waste according to types and monitor standards.

ii. Infection Control Unit

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

iii. Hospital waste categories.

Hospital waste is categorized as clinical 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.

a. 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.

b. Chemical waste.

Chemical waste may be hazardous (toxic, corrosive, flammable, and 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.

c. Pressurized containers

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

d. General waste

General waste may 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.

iv. 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).

The workers shall comply with the required procedures. (Refer to Infection Prevention & Control Policies & Procedures for details)

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

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

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

iii. 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.

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

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

vi. 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 14 or 14A cards. Unit Asset shall assist in the monitoring.

8.0 HOSPITAL AMENITIES

8.1 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.

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

8.2 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 as 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.

8.3 Public Facilities

i. *Anjung Kasih* is available as a rest place for patient's relatives who are from far and financially limited. Those who use the place shall be subjected to the available rules and regulations.

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

iii. The following are some of the other facilities in the hospital available for public use:

- Breastfeeding room
- Cafeteria
- Washroom and toilet
- Shops/kiosk
- Auto-teller machines

9.0 SUPPLIES AND ASSETS

9.1 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 Pharmacy Department. Procurement must be transacted in Pharmacy Information System (PhIS).

iii. Procurement of non-standard items shall be done by the respective Unit. Procurement must be transacted in Pharmacy Information System (PhIS).

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

v. Purchasing of food items shall be coordinated by the dietetics and catering department.

9.2 Equipment and Pharmaceutical Supplies

9.2.1 Requirement & Specification

i. Requirement of medical equipment shall be decided by the individual department / unit and coordinated by the Asset and Procurement Unit.

ii. Pharmacy Department will coordinate with individual department/unit on requirement of consumables, drugs and pharmaceutical supplies.

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

9.2.2 Delivery & Supply

i. All pharmaceutical supplies shall be delivered to the Main Store in Logistic Pharmacy except for chemical reagent, which shall be sent directly to Pathology department. The supply of consumables and medical gas shall be collected directly from the Main Store in Logistic Pharmacy and the supply of drugs shall be collected from Satellite Pharmacy or Inpatient Pharmacy.

i. Bulky equipment and non-standard consumables shall be delivered directly to the respective end user. The end user shall be present to verify the delivery. For non-standard consumables, delivery order and invoice must be copied to Main Store in Logistic Pharmacy for transaction of receiving and direct issuing in PhIS.

ii. 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.

iii. Dangerous and Psychotropic Drugs shall be stored in locked cabinet, transported in locked container, and managed only by authorized pharmacists or staff nurses.

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

9.2.3 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 or loaning of equipment to another department shall comply to the Guidelines on Asset Management and documented. (Refer *Para 8 AM 2.3 (Pendaftaran Aset) - 1PP - 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 in good condition and functioning.

v. All loan transactions are recorded in a form (*Borang Kebenaran Meminjam/ Membawa Keluar Harta Modal/ABBR-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 asset 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.

vii. Loaning of drugs to private centres is allowed during emergency, crisis or disaster. limited to life saving items. Pharmacy shall only supply the drug after approval from the Hospital Director.

9.2.4 Disposal

i. Head of department shall be responsible to submit a list of equipment to be disposed / condemned to the Asset Unit. (Refer *AM 2.6 (Pelupusan Aset) - 1PP - Tatacara Pengurusan Aset Alih Kerajaan).*

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

iii. Disposal of Psychotropic Drugs must be made in presence of Drug Enforcement Officer.

10.0 COMMUNICATION SYSTEM

10.1 Telephones and Fax

i. An external PABX line (direct dialing throughout the country) and a separate direct telephone line shall be made available for locations approved by the Hospital Director.

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

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

iv. Handphones may be provided to certain category of staff in compliance with government directives.

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.

10.2 Nurse Call System

i. A nurse call system shall be provided within each ward for patient to use when assistance is needed. The system shall be as follows:

- Each bed head shall be linked to the control at the staff base which is equipped with a sound alarm and a digital display;
- Upon activation of the call system, the wireless device which is held by a staff will beep.
- The system shall also be made available in the patient areas such as washrooms and toilets.

ii. A staff emergency call system shall be provided in Labour room to alert staff at Maternity 1 in the event of an emergency. This system shall be used at the discretion of the staff in attendance.

10.3 Public address (PA) system

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

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

10.4 Social Media

i. Current technology in various social media applications shall be adopted as a mean of communication according to Social Media Policy.

ii. Refer to *SPKPK Bil. 10/2016 Garis Panduan Penggunaan Media Sosial Dalam Perkhidmatan Penjagaan Pesakit di Fasiliti KKM* dated 31 March 2016.

11.0 ICT POLICY

11.1 The hospital shall ensure that the I.T. systems comply with all standards, policies, existing guidelines of the Ministry of Health and the central agencies such as MAMPU.

11.2 All staff shall adhere to Policy on ICT Security as in SPKPK Bil.13/2011 *Dasar dan Garis Panduan User Access Control Policy bagi Sistem Maklumat Hospital dan Klinik (HIS/CIS) KKM; Surat Pekeliling Ketua Setiausaha KKM Bil. 10/2019: Dasar Keselamatan ICT (DKICT) Kementerian Kesihatan Malaysia (KKM) Versi 5.0* dated 19 September 2019.

11.3 All preparation and provision of services based on ICT infrastructure & system shall be continuously carried out without interruption that can jeopardise the security.

11.4 Maintenance for the ICT system shall be carried out regularly. This includes preventive maintenance for both hardware and software.

11.5 Any ICT projects shall obtain the approval of the relevant authority as per latest guideline by MOH. Refer to *Surat Pekeliling Am Kementerian Kesihatan Bil. 1 Tahun 2016 (Tatacara Pelaksanaan Projek ICT Di KKM)* and *Surat Pekeliling Am Kementerian Kesihatan Malaysia Bil 2 Tahun 2016 (Garis Panduan Kesediaan Infrastruktur Teknologi Maklumat (ICT) Di Agensi Dan Fasiliti* KKM).

11.6 Only registered staff are allowed access to any available system.

11.7 Physical security

i. Control of physical access: use of security pass and lock the office when the office is left unattended.

ii. Access to server room is only limited to authorized staff or in the presence of authorized staff.

iii. Security of ICT asset: safeguard equipment and information from theft, break down, abuse and interruption of MOH activities.

11.8 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

11.9 Staff are required to self-register an account with the hospital's MyWorkspace during the day of reporting duty.

11.10 MOH Official Email

i. All staff may apply for an official e-mail address through ICT unit.

ii. Inactive account more than 90 days will be removed from the system by email administrator.

iii. Any suspicious email received should be reported or forwarded to ICT Unit (ict.hsibu@moh.gov.my).

11.11 Incident Reporting

i. Loss of any pieces of ICT equipment must be reported (laptop, computer, switch, server, mobile phone, ups, removable media, etc)

11.12 Helpdesk ICT

i. Staff who need technical support may lodge the ticket via online system at http://apps.hsibu.moh.gov.my/helpdesk, or

ii. Email to ict.hsibu@moh.gov.my

12.0 GREEN INITIATIVES

12.1 The hospital is committed to ensure the principle of green technology is adhered to as much as possible without compromising the requirement of infection control. This allows reduction of environmental risk and minimization of pollution and resource use.

12.2 The sustainable programme shall actively address energy management, indoor air quality (IAQ), and reduction, re-use and recycle of waste.

12.3 Energy conservation shall be actively promoted, practiced and monitored. These include implementing Energy Performance Contracting projects, strengthening monitoring of the preventive maintenance of facilities such as HVAC system, building envelope and the use of energy saving appliances or devices.

12.4 Green initiatives shall be carried out in all department and units.

12.5 Government Green Procurement (GGP) initiative shall be applied where possible.