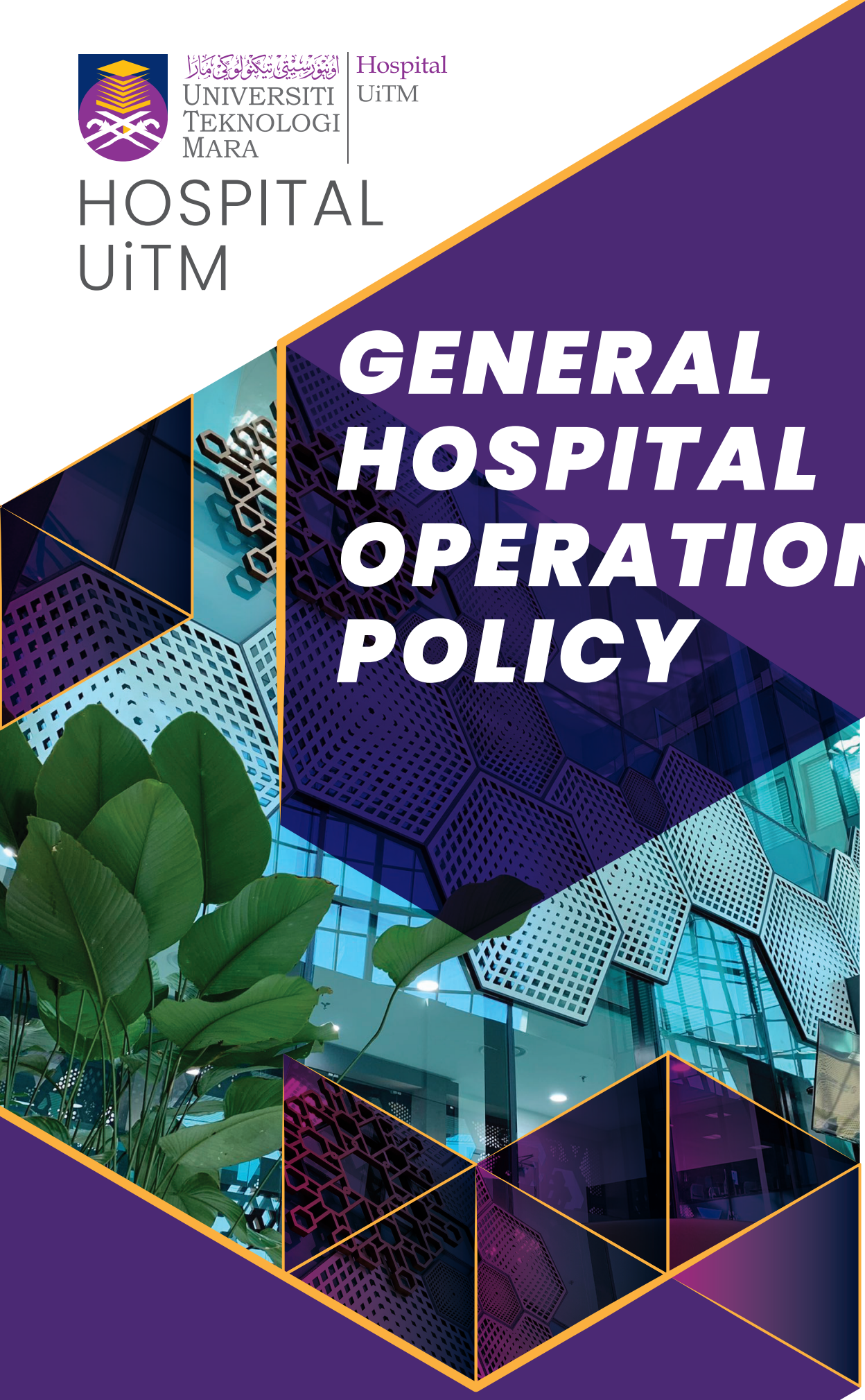
UNIVERSITI TEKNOLOGI MARA
Hospital UiTM

HOSPITAL UiTM

GENERAL HOSPITAL OPERATIONAL POLICY



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Hospital UiTM 2021

GENERAL HOSPITAL OPERATIONAL POLICY

UNIVERSITI TEKNOLOGI MARA | Hospital UiTM

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HOSPITAL
UiTM

FOREWORD & PREFACE

FOREWORD

Hospital staff often face problems for which information already exists, either in documented form or undocumented practices. This information may be fragmented, scattered and unevaluated. Realising this, efforts were undertaken to collect such information, analyse and document them in an accessible and friendly form.

Thus, after much commendable hard work by those involved in the fruition of this book, I am proud to hold in my hands, the General Hospital Operating Policy (GHOP).

GHOP is our very own documentation of guidelines to assist staff members in their efforts to serve their best to the Hospital and University. This book provides clarity to hospital policies and practices, helping staff members make better decisions in line with our aspiration to provide consistent and excellent healthcare to the masses.

GHOP covers five sections, of which the most important sections, I and II, describing in full the hospital's policies and basic principles. All the bases are covered; from the moment of patients' arrival to the hospital to their discharge, hospital organisational charts to disaster management and contingency plan.

I urge each and every one of my fellow staff members to make full use of this guidebook, especially in these trying times, to understand the fundamentals of the management of the hospital, and its day-to-day operation.

In light of the recent challenges faced by hospital staffs, I am grateful for the timely efforts brought forth by the editorial panel and secretariat of GHOP. I truly believe that GHOP will be a helpful guide and source of information for numerous practical applications. Thank you.

Prof. Ts.
Dr. Hajah Roziah Mohd Janor
Vice Chancellor,
Universiti Teknologi MARA

PREFACE

Alhamdulillah, with His grace, I am pleased to introduce our very own General Hospital Operating Policy (GHOP), which illustrates the Hospital and the University's commitment to excellence in serving the Ummah.

This document is a statement of intent. It serves as a roadmap for day-to-day operations of Hospital University Teknologi MARA (HUiTM). This document will provide us with the proper guidance, uniformity, accountability and efficiency during the deliverance of healthcare, catapulting us to the next level in patient safety and well-being, bringing forth a safer and more conducive workplace for the hospital staff. Through this document, we aim to guide doctors, nurses and healthcare workers in understanding their roles and responsibilities better.

This document contains general policies related to the management and operations of the hospital. It also contains the policies on hospital and clinical governance, disaster management and contingency plans for the hospital.

The stepping stones have been laid here. The future holds hope for those who strive for it. Aim higher and achieve goals you never expect. It is our aspiration that this policy will be the leading principles in bringing the Hospital and the University to greater heights.

Prof. Dr.
Sazzli Shahlan Kasim
Director, Hospital UiTM

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ANJUNG
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THE POLICY

Chapter 1:

Organisational Overview

Sazzli Shahlan Kasim, Ahmad Izuanuddin Ismail, Izzat Ismail, Suraya Abd Razak, Mohd Rizal Nordin.

HUiTM Puncak Alam, PPUiTM Sg Buloh, and PPUiTM Selayang are committed to providing consistent, excellent care. The hospital revolved around the principles outlined below consistent with the university aspiration. Our organization is structured to provide robust governance to provide clarity for staff members.

1.1 Vision, Mission and Objectives

1.1.1 Vision:

- To be a globally renowned academic healthcare centre.

1.1.2 Mission:

- Enhancing humanities through professional development, impactful research and state of the art healthcare delivery.

1.1.3 Objectives:

- To be a premier academic healthcare centre.
- To nurture quality compassionate healthcare.
- To champion cutting edge avant-garde research.
- To innovate effective sustainable healthcare finance.

1.2 Core Values

Our core values uphold an enduring set of values which are **Excellence, Synergy** and **Integrity.**

1.2.1 **Excellence:**

- Practicing internal quality standards to fulfil the stakeholder's requirements and expectations.

1.2.2 **Synergy:**

- Collaborating seamlessly to maximise productivity that benefits industry and society.

1.2.3 **Integrity:**

- Embracing honesty, respect and transparency to achieve the highest ethical standard professionalism.

1.3 Organisational Structure

1.3.1 Hospital Overview

i. Hospital Universiti Teknologi MARA (HUiTM) encompasses three (3) facilities located in Puncak Alam, Sungai Buloh and Selayang.

ii. HUiTM is managed by the *Jawatankuasa Pengurusan Hospital (JPH)* which is headed by the Hospital Director and is directly responsible to the *Majlis Pengurusan Hospital (MPH).* The JPH is responsible for the administration and management of HUiTM. MPH is chaired by the Vice-Chancellor and meets four times a year. The MPH reports to the *Lembaga Pengarah Universiti (LPU)*, the highest governing body in Universiti Teknologi MARA.

iii. Being an academic healthcare facility, HUiTM strives to achieve academic excellence at the same time providing the highest level of clinical services to its clients.

iv. HUiTM is a specialist-led Hospital with 400 beds, womb to tomb services highlighting woman & childcare, minimally invasive surgery, geriatric and advanced rehabilitation facilities. The Hospital will serve the North Selangor area with an estimated population of 700,000 people. It complements the neighbouring Ministry of Health (MOH) facilities as well as private hospitals in providing specialist care to all patients.

v. *Pusat Perubatan Pakar Universiti Teknologi MARA (PPUiTM)* Sungai Buloh started its operation in 2010, having a total of 118 beds and serves as a referral centre for cardiac and vascular disease. Its services include emergency, in and out-patient, diagnostics, pharmacy, procedure areas and operating theatres.

vi. PPUiTM Selayang has been operational since 2008 and focuses on Primary Care Medicine as well as being a Wellness Centre. This facility provides out-patient consultations, diagnostics, including radiological examination and pharmacy.

vii. HUiTM adheres to GCP[1] and the Declaration of Helsinki[2] on Ethical Principles for Medical Research Involving Human Subjects in carrying out all clinical trials and research within its GCP vicinity.

viii. HUiTM adheres to the Universiti Teknologi MARA Act 1976[3], Statutory Bodies (Discipline and Surcharge) Act[4] and other relevant laws, rules, regulations, policies and circulars approved by the Government to ensure proper governance, operations, administration and management.

1.3.2 Organisational Governance

i. There shall be a Hospital Director appointed by the Vice-Chancellor who shall head the Hospital and responsible for the overall management of the Hospital. The Hospital Director shall be an employee of UiTM.

ii. There shall be a Deputy Director (Clinical Services) and a Deputy Director (Clinical Support Services).

iii. In the absence of the Hospital Director, the Deputy Director of Clinical Services shall perform his/her duties and assume the responsibilities of the Hospital Director.

iv. There shall be a Deputy Director of Finance to oversee financial matters of the Hospital. The Deputy Director of Finance shall be responsible for the preparation of the budget, procurement, revenue, donations and other aspects related to the finance of the Hospital.

v. There shall be a Deputy Director of Administration and Management to oversee the administrative, management and security matters of the Hospital.

[1] Malaysian Guideline for Good Clinical Practice 4th Edition 2018.
[2] World Medical Association. (2013). Declaration of Helsinki, Ethical Principles for Scientific Requirements and Research Protocols. Bulletin of the World Health Organisation, 79(4), 373.
[3] Universiti Teknologi MARA Act 1976 (Act 173).
[4] Statutory Bodies (Discipline and Surcharge) Act 2000 (Act 605)

vi. Each Clinical Department shall be headed by a Head of Department or, in his/her absence, by the most senior consultant appointed by the Hospital Director.

vii. Non-Clinical Departments shall be headed by officers trained in their respective disciplines.

viii. The duties and responsibilities of the Head of Departments shall be prescribed by the Hospital Director following the functions and objectives of the Hospital.

ix. There shall be a Head of Nursing Services to oversee the nursing services of the Hospital. The Head of Nursing Services may be assisted by Matron and Nursing Sisters.

x. The Matron will be responsible for the Central Sterile Service Unit (CSSU), laundry and linen services, infection control, and nurses' accommodation.

xi. There shall be a Head of Assistant Medical Officer (AMO) who shall be responsible for coordinating services provided by the AMO. The Head of AMO shall also be responsible for transport and ambulance services of the Hospital.

xii. The Infrastructure Department shall be headed by Head of Engineering, assisted by engineers, assistant engineers and technicians. The engineer shall ensure aspects related to outsourced services including hospital waste management, fire safety, maintenance of grounds, landscaping, maintenance and repair of all civil, mechanical, electrical and biomedical installations are appropriately undertaken by the appointed company.

xiii. The Infostructure Department shall be headed by the Head of Infostructure. He/She shall be responsible for the operations, maintenance and monitoring of Information & Communication Technology (ICT) systems installed in the Hospital.

1.3.3 Organisational Structure

A. Organisational Chart

Refer Appendix 1: HUiTM Organisational Chart

B. Committee

i. The establishment of committees and working committees under the Hospital shall subject to the laws and regulations of UiTM[3].

ii. To ensure good practice, the Hospital may refer to the circular from the Director of Health (DG) Malaysia to facilitate the operations of the Hospital[5].

iii. There shall be committees in HUiTM that overlook the clinical services and the administration services to ensure the smooth delivery of care and running of the Hospital. *(Refer to Appendix 2)*.

[3] Universiti Teknologi MARA Act 1976 (Act 173).
[5] Surat Pekeliling Ketua Pengarah Kesihatan Bil 7/2000 – Garis Panduan Struktur Organisasi Pengurusan Hospital. Reference No: (15) in KKM-87(P20/702), 22 Disember 2000.

1.3.4 Departments and Units

Hospital UiTM shall establish departments and units which include but not limited to the following:

A. Clinical Departments and Units

i. Anaesthesiology and Intensive Care Department

ii. Clinical Diagnostic Laboratory Department

- Anatomic Pathology
- Chemical Pathology
- Haematology and Transfusion Medicine
- Medical Microbiology
- Parasitology

iii. Cardiology Service Centre

iv. Cardiovascular and Thoracic Surgery Service Centre

v. Daycare Unit

vi. Emergency Department

vii. Forensic Medicine Service Centre

viii. General Surgery Department

- Breast & Endocrine
- Colorectal
- Hepatobiliary

ix. Infection Control Unit

x. Internal Medicine Department

- Dermatology
- Endocrinology
- Gastroenterology
- Geriatric
- Haematology
- Infectious Disease
- Neurology
- Oncology
- Palliative Care
- Respiratory
- Rheumatology

xi. Nephrology Service Centre

xii. Obstetrics & Gynaecology Department

xiii. Ophthalmology Department

xiv. Dental Service Centre

xv. Orthopaedic and Traumatology Department

xvi. Otorhinolaryngology Department

xvii. Paediatrics Department

xviii. Plastic Reconstructive and Aesthetic Service Centre

xix. Primary Care Medicine Department

xx. Psychiatry Department

xxi. Public Health & Preventive Medicine Department

xxii. Radiology Department

xxiii. Rehabilitation Medicine Department

B. Clinical Support Departments and Units

i. Central Sterile Supply Unit

ii. Dietetic and Food Service Department

iii. Infostructure Department

iv. Infrastructure Department

v. Medical Social Work Department

vi. Nursing Department

vii. Patient Information Department

viii. Pharmacy Department

C. Non-Clinical Departments and Units

i. Cardiovascular and Lung Research Institure

ii. Corporate Communication Department

iii. Finance Department

iv. Human Resource and Administration Department

v. Quality Improvement and Patient Safety Department

vi. Research, Innovation & Industrial Linkages Department

vii. Legal Office

1.4 Client's Charter

HUiTM is committed to deliver ethical, quality and efficient services to ensure that:

i. The needs for healthcare delivery fulfil the requirements of the available regulations and standards.

ii. All patients will be provided with professional and customer-friendly services.

iii. Patients may have access to medical information which relates to their condition and treatment.

iv. Patients may accept or refuse any medication, investigation or treatment and be informed of the likely consequences of doing so as well as provided with alternatives where available.

v. All patients will be ensured confidentiality of their medical condition.

vi. Grievances will be dealt with accordingly.

vii. The needs for teaching and learning for students and staff fulfil the requirements of the available regulations and standards.

viii. Research conducted adheres to the latest GCP guidelines[1].

[1] Malaysian Guideline for Good Clinical Practice 4th Edition 2018.

Chapter 2:

Management and Operations

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2.1 General Administration

2.1.1 Letters and Documents

i. The Administration Department 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 filling system of official documents. Both incoming and outgoing letters shall be filed accordingly.

iii. Incoming letters/documents, whether in electronic or hard copy form, shall be registered, minutes recorded and despatched to the respective department/unit within a specified time. Urgent letters shall be despatched immediately, and the respective department/unit informed via telephone communication.

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

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

vi. Confidential letters and documents shall be handled according to the relevant laws and regulations.

vii. Letters and 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 UiTM and the National Archive Department[6][7].

viii. All other departments in the Hospital shall adhere to this guideline when handling letters and documents.

2.1.2 Office Equipment and Supplies

i. The Administration Department shall coordinate the requirement of office equipment and supplies of the Hospital and distribution to the relevant units or departments.

ii. The Head of Administration Department shall be responsible for maintaining the asset and inventory list and ensuring proper and efficient use of equipment and supplies.

iii. To ensure efficiency, certain office equipment may be shared among several departments or units. Shared equipment shall be under the responsibility of the department/unit where the equipment is/are located.

iv. The Hospital assets shall be managed and administered according to the current practice directions and circulars of UiTM[8].

2.1.3 Meeting Room Facilities

i. The use of meeting rooms and other facilities like auditorium, seminar rooms etc. shall be coordinated according to the current practice directions and circulars of UiTM.

[6] National Archives Act 2003 (Act 629) Laws of Malaysia.
[7] Dasar Pengurusan Rekod Universiti Teknologi MARA.
[8] Pekeliling Bendahari Bil. 3/2018 – Tatacara Pengurusan Aset Alih UiTM.

ii. The general meeting rooms shall be under the care of the Administration Department.

iii. The meeting room under specific department/unit shall be under the care of the department/unit.

2.2 Finance

2.2.1 Budget

An adequate budget setting process shall be in place, in line with the Hospital's needs and objectives, according to the current practice directions of UiTM[9].

A. Budget Preparation

i. At any time during the fourth quarter of a particular year, the Hospital Director and Deputy Director (Finance) shall convene meeting with the Head of Departments to provide guidelines for budget preparation.

ii. The Head of Departments shall be responsible for preparing estimates of the current year, as well as revenue and expenditure estimates for the upcoming year. The Head of Departments must pay close attention to historical trends and current needs when determining estimates, programme agreement, evaluation and to prepare a financial report, if required, at the end of the budget year.

iii. The Head of Departments shall prudently manage the budget, adhering to financial regulations and procedures and be responsible for formulating justifications for additional budget.

iv. The *Jawatankuasa Pengurusan Kewangan dan Akaun (JPKA)* shall oversee finance and accounts related issues including expenditure status, budget reallocation and additional budget requirement.

v. The Hospital Director shall be fully responsible for the management of allocation and expenditure of the Hospital.

B. Budget Analysis

i. Within ten days after the end of each month, a written budget analysis shall be performed by the JPH and JPKA consisting of the following elements:

- Actual revenues and expenditures will be compared to budgeted amounts; both for the current month and the year-to-date.
- Significant variances will be noted and their causes determined.

ii. The Hospital Director will forward the quarterly budget analysis, in whole or in summary, to the MPH along with recommended actions, if necessary.

[9] Arahan Perbendaharaan 59 - Peraturan Kewangan Dan Perakaunan Universiti Teknologi MARA

2.2.2 Cash Management

A. Cash Forecast

i. Guidelines for preparing cash forecast for Hospital UiTM requires a manual check.

ii. Cash forecasts shall be prepared quarterly.

iii. The Management shall be updated on the cash status at every management meeting.

iv. All investments and borrowings for any amount shall require approval by the JPH.

B. Cash Handling

All cash and bank transaction involving the handling of cash shall be carried out in accordance with the government procedures, practice directions and circulars of UiTM and with proper authorisation, control, monitoring, and properly classified in the accounting records of the Hospital. The same level of care and diligence shall be carried out in the following transactions:

i. Opening and authorisation of new bank accounts

ii. Closing Bank Accounts

iii. Check Issuance

iv. Wire Transfers and Cash Disbursements

v. Authorised Bank Signatories

vi. Cash Receipts, Bank Reconciliations

vii. Petty Cash

2.2.3 Procurement

All procurements including purchase authority limits shall be carried out in accordance with the government procedures, practice directions and circulars of UiTM[10].

2.2.4 Payment

i. The Finance Department shall be responsible for recording purchases and payments.

ii. Accounts payable shall be reconciled periodically.

iii. Payments made by or to the Hospital shall be processed, monitored and reconciled following the government procedures, practice directions and circulars of UiTM[11].

2.2.5 Claims and Loans

i. All claims and loans shall adhere to the government procedure, practice directions and circulars of UiTM[11].

[10] Pekeliling Bendahari Bilangan 4 tahun 2012 - Garis panduan berkenaan kaedah perolehan bagi bekalan dan perkhidmatan secara pembelian terus.
[11] Pekeliling Bendahari Bil 4 tahun 2017 - Garis Panduan Pengurusan Pendahuluan Pelbagai, Pelarasan dan Tuntutan Perbelanjaan Pelbagai Yang Telah Didahulukan.

ii. Staff are required to submit claim forms within the following month and in the same year. The claim forms have to be completed, signed and attached with the necessary documents.

iii. Head of Department/Unit shall verify and validate the claims before submitting them to the Finance Department.

iv. Government and University loan applications shall be submitted based on eligibility and attached with the relevant forms and supportive document.

2.2.6 Hospital Charges

i. Fees shall be charged in accordance to the approval of *Jawatankuasa Kewangan dan Pembangunan (JKP)* UiTM.

ii. Procedures not listed in the Fee Order shall be forwarded to the JKP for approval of the fee.

iii. The Hospital shall make available the information on Hospital fees or charges to all parties.The deposit shall be collected prior to admission except for emergency cases where a deposit may be collected later.

iv. The deposit shall be collected prior to admission except for emergency cases where a deposit may be collected later.

v. The Hospital shall take all possible measures to ensure proper patient payment collection.

vi. Any exemption or reduction to Hospital bills shall be subjected to approval by the *Jawatankuasa Pengurangan dan Pengecualian Hospital UiTM.*

2.2.7 Billing and Payment

i. For paying patients, the Hospital bill shall be given upon discharge and payment must be settled at the Revenue Unit or the Emergency Department (ED) revenue counter after office hours.

ii. Interim bills (summarised bills) shall be generated in the ward and given to the patient during their stay in the Hospital. Long staying patients shall be informed of their accumulated bills at intervals.

iii. For patients with valid Letter of Guarantee, Hospital bills shall be sent to their employer. The Letter of Guarantee shall be submitted to the Revenue Unit for verification and to be kept until settlement of the Hospital bill.

iv. For appliances/materials not provided by the Hospital, patients shall be billed separately by the designated supplier and shall be paid accordingly by the patient (e.g. intraocular implant, orthopaedic implant etc.)

v. The Hospital shall receive payment in cash, money order, postal order, bank draft, bankers' cheque, online banking or credit/debit card. Personal cheques are not accepted.

vi. Receipts (either paper or electronic) shall be issued upon payment.

vii. Revenue collection shall be carried out by authorised personnel only at designated revenue counters.

viii. A final bill shall be issued at the revenue counter or sent to the address stated in the Letter of Guarantee for settlement of the bill.

2.3 Human Resource

2.3.1 Human Resource Planning

i. The Hospital management shall strive to provide appropriate numbers of people with the required skills in the Hospital. The Hospital management is responsible for human resource training in accordance with service needs and expansion plan.

ii. Orientation

- Newly appointed staff shall be informed about the terms and conditions of appointment in following the laws and regulations of UiTM[3] [4].
- Newly appointed staff are required to attend orientation courses and/or programmes organised by UiTM.
- The orientation programme shall be organised for all new staff which includes an overall briefing on the Hospital policies, procedures, rules and regulation and their roles and responsibilities.
- Specific briefings shall be given by the departments and units.
- Hands-on training on ICT skills shall be arranged for all staff.

iii. Placement

- Placement of staff to departments or units shall be based on qualification, specialised training received and service needs.
- The department/unit head shall be responsible for the placement and job description within the department/unit.
- Deployment and rotation of staff to other departments and units may be carried out as and when necessary.
- The Hospital Director is responsible to ensure the placement of sufficient ICT officers for the efficient running of the hospital.
- Reference may be made to the following documents regarding placement[12][13][14].

iv. Work Attendance and Leave

- Staff shall record their daily attendance and movements within working hours using the appropriate person attendance system, subject to the current registrar circular[15]. Staff requesting for time-off during office hours shall complete the *Borang Kebenaran Untuk Meninggalkan Pejabat Dalam Waktu Bekerja.*

[3] Universiti Teknologi MARA Act 1976 (Act 173).
[4] Statutory Bodies (Discipline And Surcharge) Act 2000 (Act 605).
[12] SPKPK Bil.4/2010 Garis panduan Bertugas atas Panggilan Untuk Pegawai Perubatan dan Pegawai Perubatan Siswazah di Hospital-Hospital KKM, 12 March 2010.
[13] Approval of JKP (Locum), Ministry of Health Malaysia.
[14] Buku Panduan Program Pegawai Perubatan Siswazah, Edisi 2012, KKM.
[15] Pekeliling Pendaftar Bil. 7/2010 - Kebenaran Untuk Meninggalkan Pejabat dalam Waktu Bekerja.

- Head of Department/Unit shall be responsible for monitoring their staff daily attendance/movement.
- Application of leave shall be done before taking the leave. The use of HR2U (Leave and time off application) for leave application is compulsory.
- Staff shall inform their Head of Department/Unit if he/she is not well to be present at work and/or has been given a Medical Certificate for leave (MC).
- Staff participating in the Medical and Humanitarian Aid Mission shall be accorded a maximum of 14-day non-recorded leave (including weekends and holidays) when the mission is organised by a recognised body. For staff participating in Hajj/pilgrimage, they shall be recorded as doing medical service in Arab Saudi with permission.

2.3.2 Performance Evaluation

i. Every staff shall have a MyPortfolio which contains the job description, responsibilities and related work guidelines and procedures.

ii. At the beginning of the year, staff will discuss with his/her respective Head of Department to prepare his/her annual work target and key performance indicators (KPI).

iii. The Head of Department/Unit shall monitor and evaluate his/her staff competencies.

iv. The performance evaluation shall be carried out biannually and at appropriate intervals using the standard format in a just and fair manner.

2.3.3 Ethics and Discipline

i. Behaviour at work and dress code:

- The core values of Hospital UiTM i.e. excellence, synergy and integrity shall be internalised and uphold by all staff while performing his/her duties.
- During working hours, staff shall professionally render services to uphold the image of the Hospital.
- Staff shall wear his/her respective uniform or proper working attire when he/she is at work.
- Name tags and hospital identification card shall be worn at all times as part of the uniform/working attire. Ethics and discipline of all staff shall adhere to the current practice direction and circulars of UiTM[16].

ii. Disciplinary Problem

- Monitoring of staff performance shall be continuous. Staff with disciplinary problems shall be given counselling before being referred for disciplinary action. Disciplinary actions shall be referred to UiTM Integrity Unit and shall be subject to the laws and regulations of UiTM[4].

[16] Pekeliling Pendaftar Bil. 15/2011 Etika Pakaian dan Sahsiah Rupa Diri bagi Staf UiTM and SPKPK Bil.1/2000 Amalan Etika Profesion Perubatan Yang Baik, 26 May 2000.
[4] Statutory Bodies (Discipline And Surcharge) Act 2000 (Act 605).

2.3.4 Staff Welfare and Safety

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

ii. The Hospital shall establish Jawatankuasa Keselamatan dan Kesihatan Pekerja (JKKP) to look after the wellbeing and safety of the staff. (Refer to OSHA guidelines for details).

iii. Clubs or associations will also be created to provide opportunities for staff to get together, participate in sport or carry out other recreational activities.

iv. The Hospital shall establish a staff clinic to provide health services to all staff.

v. The Hospital shall have an Ex-Gratia Work Disaster Scheme. This scheme provides compensation to Hospital staff stricken by disasters while carrying out work that causes permanent disability or death, including those victimised because of retaliation as a result of the action taken in the course of official duties. An officer is covered at all times while on official duty including:

- While travelling to and from home to workplace;
- While travelling to and from the workplace to the residence at an approved mealtime.

vi. The Hospital must provide a safe working environment to protect staff, visitors, contractors and patients from possible harm and injury

vii. Occupational accidents and occupational diseases shall be notified accordingly.

2.4 Management of Assets

These policies will ensure proper recording and accountability for fixed assets and to establish and implement controls necessary to protect the assets of the HUiTM.

2.4.1 Acquisition of Fixed Assets

i. The requirement of a fixed asset shall be decided by the individual department/unit and coordinated by the Procurement Department/ Administration Department.

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

iii. The Procurement Department/ Administration Department employee shall submit the invoice with the supporting documents to the Finance Department to record the purchase of fixed assets and process the payment to the vendor.

iv. The Finance Department shall review the invoice with the supporting documents and puts his/her initial on the invoice to indicate approval of recording the fixed assets and initiating the payment process.

v. The Finance Department shall update the fixed assets register and prepare the identification tags.

2.4.2 Receiving of Donated Fixed Assets

i. The Administration Department is responsible for receiving donated fixed assets and shall prepare a Receiving Report of the donated fixed assets.

ii. The Administration Department shall submit the Receiving Report to the Finance Department to record the donated fixed assets.

iii. For UiTM's review and approval, the Finance Department shall submit the Receiving Report to:

- *Majlis Eksekutif Universiti (MEU) UiTM*
- *Jawatankuasa Kewangan Dan Pembangunan (JKP) UiTM*

2.4.3 Fixed Assets Identification

The Infrastructure Department is responsible for identifying all the fixed assets. An identification number shall be assigned and tagged for all fixed assets (other than land, buildings). This tag must have a unique identification number that will be associated with the asset and becomes part of the asset's record; with tag labels; and shall maintain a list of the used identification codes.

2.4.4 Depreciation of Fixed Assets

i. The entire cost of an asset must be depreciated. Depreciation is allocated monthly over the estimated useful life of the capital asset.

ii. Depreciation is to commence in the first month after the asset is placed into service.

iii. Fixed assets will be depreciated on a straight-line method over their estimated useful life.

2.4.5 Equipment/Inventory List and Loan

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

ii. Equipment shall not be moved or transferred to another hospital without prior approval of the Hospital Director. Any movement of equipment shall comply with the circular of UiTM[8].

iii. For interdepartmental movement of equipment in HUiTM, both departments involved must keep clear documentation of the movement.

iv. The loaning of equipment is limited to items required 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.

v. There will be a deposit charge for loaned equipment to the other Hospital.

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

[8] Pekeliling Bendahari Bil. 3/2018 – Tatacara Pengurusan Aset Alih UiTM.

vii. Supplies may be loaned to another Hospital but must be replaced with an identical item or an item of equivalent value that is acceptable to the Lender. Delivery and return of the equipment or supplies is the responsibility of the Borrower.

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

2.4.6 Disposal of Fixed Assets

i. Head of Department shall be responsible to submit a list of equipment to be disposed of/condemned to Administration Department and other relevant practice directions and/or Circulars issued by UiTM [8][17].

ii. The Administration Department is responsible for identifying the fixed assets that need to be disposed of and should obtain the required approvals.

iii. The Administration Department shall provide the Financial Department with a copy of the approved forms.

iv. The Financial Department shall review the request and the report will be submitted to the Jawatankuasa Pelupusan Aset for final review and approval.

v. The Administration Department shall be responsible for following up on disposing of the assets based on the committee's recommendation report and the approval.

2.5 Infostructure

2.5.1 The Hospital shall ensure that the ICT systems comply with all standards, policies, existing guidelines of the central agencies and other law, policies or circulars issued by the government and UiTM from time to time[18][19].

2.5.2 The Hospital shall ensure that the ICT hardware and software are able to support the Hospital to perform its function and daily operations.

2.5.3 Maintenance for the ICT system shall be carried out regularly according to an agreed schedule. This includes preventive maintenance for both hardware and software. Software applications and system shall require upgrading at intervals/ updated version.

2.5.4 All services, hardware and outsourced system shall be carried out by an appointed company that is accountable to Infostructure Department.

2.5.5 Staff shall be subjected to disciplinary action for any breach of the Hospital ICT Policy.

2.5.6 Official electronic correspondence shall use the UiTM mail account.

[8] Pekeliling Bendahari Bil. 3/2018 – Tatacara Pengurusan Aset Alih UiTM.
[17] Surat Pekeliling Bendahari Bil. 1/2019 - Penstrukturan Semula Jawatankuasa Pelupusan Aset Alih UiTM Dan Jawatankuasa Pelupusan Aset Tak Alih UiTM. Directive Reference - https://myfinancial.uitm.edu.my/new/index.php/utama/116-e-pekeliling#jabatan-pengurusan-perolehan-aset-jppa.
[18] Malaysian Administrative Modernisation and Management Planning Unit (MAMPU)
[19] Dasar Keselamatan ICT UiTM Version 2, 2018

2.5.7 In the unlikely event of an ICT disaster e.g. HIS unplanned downtime or power/ generator set failure, a Business Continuity Plan (BCP) shall be authorised by the Hospital Director to revert to manual documentation.

2.5.8 Planned downtime shall be scheduled regularly at scheduled intervals to test BCP and refresh the user on manual documentation.

2.5.9 ICT facilities shall be made available to staff in accordance with their responsibilities and privileges written in the UiTM ICT Policy[20].

2.6 Infrastructure

The Infrastructure Department shall be responsible for the overall coordination of these services; cleansing, linen & laundry, healthcare & clinical waste management, biomedical engineering, Facility Management System and Facility Engineering Management System.

2.6.1 Infrastructure management

i. A liaison officer for each service shall be appointed to monitor and coordinate all the activities and to ensure compliance to the Concession Agreement (CA), Master Agreed Procedures (MAP), Technical Requirement and Performance Indicator (TRPI) and the Hospital Specific Implementation Plan (HSIP). The HSIP is a dynamic document that shall be reviewed yearly and may be amended when necessary and endorsed by the Hospital Director.

ii. The Deputy Director (Clinical Support) shall be the overall coordinator and have regular meetings with the Liaison Officer to discuss issues and remedial actions to be taken to improve the services.

iii. There shall be a monthly committee meeting to discuss and decide on deductions for non-conformance.

iv. The Infrastructure Department is technically responsible to monitor, evaluate, verify work done and deduction to the Concession Company.

2.6.2 Cleansing

i. Cleansing shall be carried out in following the schedule as agreed in the HSIP.

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

2.6.3 Linen & laundry

i. All linen shall be delivered in a manner that 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 and shall follow a designated route.

iii. Supply of clean linen shall be on a top-up basis and comply with the standard of each ward/unit/department/Operation Theatre (OT) as agreed.

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

[20] Garis Panduan Pengurusan ICT UiTM Bil. 06 Tahun 2020.

2.6.4 Healthcare and clinical waste management

i. Waste shall be handled in accordance with the type of wastes with standard precaution and infection control measures. Types of waste include clinical/ medical waste, e-waste, general/solid waste, and recycled waste.

ii. The transportation of clinical and general waste shall follow a designated route as agreed by Hospital management.

iii. The chemical waste shall be handled appropriately in accordance with existing acts. All clinical wastes containing infectious and contaminated human tissues, blood, body fluids, excretions, drugs, needles and other related materials shall be treated as scheduled wastes according to existing laws, regulations and practise guidelines[21],[22] [23] [24].

2.6.5 Biomedical Engineering

i. The Concession Company shall be responsible for carrying out Planned Preventive Maintenance (PPM) according to the schedule recommended by the manufacturers of equipment and the CA. The Concession Company shall be responsible for carrying out the PPM according to procedures recommended by the manufacturers of equipment.

ii. The Infrastructure Department shall rectify any breakdown (corrective maintenance) within the shortest possible time as specified in the TRPI.

iii. All departments shall maintain an updated inventory of all equipment and assets in the department. The Head of Departments shall ensure that these equipment are serviced regularly and maintained by the concession company.

2.6.6 Facility Management System

i. The Concession Company shall prepare training programmes, topics and schedule for future development training plans.

ii. The Infrastructure Department shall confirm training programmes, topics and schedule for future development training plans.

iii. The Concession Company shall conduct and document training programme as planned for users. The Infrastructure Department shall arrange for users to attend a training programme.

2.6.7 Facility Engineering Management System

i. The Infrastructure Department shall establish the detailed scope of work in the Technical Requirements and Performance Indicators (TRPI) document for the Facility Engineering Maintenance Services.

ii. The Concession Company shall confirm the detailed scope of work.

iii. Maintenance Procedures for specific systems shall be developed in Project Operation Guidelines (POG)/SOP.

[21] Environmental Quality Act 1974 (Act 127) Laws of Malaysia
[22] Guidelines on Chemical Management in Health Care Facilities, Ministry of Health 2010
[23] Guidelines on The Handling and Management of Clinical Waste in Malaysia, 3rd Edition 2009, Department of Environment, Malaysia 2009
[24] Environmental Quality (Scheduled Wastes) Regulations 2005

2.7 Outsourced Services

2.7.1 Security Services

i. The security services in Hospital may partly be privatized. Scope of services shall be based on the agreed contract.

ii. The service shall be operated by an appointed licensed security agency and managed by the Hospital.

iii. The security service shall ensure the safety of Hospital and public properties. The Scope shall encompass;

- Control of the movement of patients, visitors and staff in the Hospital area where only authorised persons are allowed.
- Ensuring the safety of Hospital assets and properties.
- Ensuring smooth movement of vehicle traffic in accordance with traffic law.
- Ensuring physical safety of staffs, patients and visitors including appropriate response in the event of risk, hazard or disaster.

iv. The security plan shall include standard operating procedures including scheduled patrol, outlet check, visitors check, staff check and 24-hour security location.

v. The security system shall also include operational procedures in the event of special circumstances such as mass casualty, dignitaries' visits, evacuation, outbreaks and fire. These areas shall be demarcated by the securities personnel. This plan should cover the following items:

- Safety of site of evacuation
- Safety of building left unattended
- Redirection of vehicle traffic
- Control of crowd, press and victims and their belongings
- Ensuring access of authorised personnel to the location

vi. All security personnel shall be vetted by the police to ensure there are no security personnel with criminal records. Security personnel should undergo a medical examination to ensure they are fit to perform their duties.

vii. Appropriate technologies may be used such as electronic access card, security cameras and automatic parking gates.

2.7.2 Food Services

i. Production and supply of diet may be carried out by the appointed outsourced food and beverage service company. The food and beverage service company shall be accountable to the Dietetic Department of the Hospital.

ii. Food shall be prepared according to the Food and Beverage Service Contract Specification prepared by the Hospital.

iii. Kitchen facilities and equipment are the Hospital's assets and rented to the outsourced food service company. Maintenance of equipment shall be done by the appointed Concession Company. Payment for utilities, rented facilities used by the food services company shall be made to the Hospital according to the contract.

iv. Food shall be prepared according to guidelines by the Dietetic Department.

v. Food preparations shall comply with the Hazard Analysis and Critical Control Point (HACCP).

vi. The Hospital canteen, cafeteria, and Hospital kitchen shall be regularly inspected to ensure that it meets the standard hygiene requirement by current laws and regulations[25] [26].

vii. Food premises in the Hospital are subjected to regular inspections by the in-house Assistant/Environmental Health Officer (*Penolong Pegawai Kesihatan Persekitaran*).

2.8 Operating and Visiting Hours

2.8.1 General

i. The Hospital operational hours are as follows:

Service	Day	Time
Emergency Department	Monday - Sunday	24 Hours
Specialist Clinics	Monday - Thursday	8.00 am - 1.00 pm 2.00 pm - 4.00 pm
	Friday	8.00 am - 12.30 pm 2.45 pm - 4.00 pm
	Weekend & Public Holidays	Closed
Labour Ward	Monday - Sunday	24 Hours
Inpatient Pharmacy	Monday - Friday	8.00 am - 8.00 pm
	Weekend & Public Holidays	12.00 pm - 4.00 pm

[25] Food Act 1983
[26] Food Regulations 1985

Service	Day	Time
Outpatient Pharmacy	Monday - Friday	8.00 am - 5.00 pm
	Weekend & Public Holidays	12.00 pm - 4.00 pm
Daycare OT	Monday - Friday	7.00 am - 9.00 pm
Daycare Endoscopy	Monday - Friday	8.00 am - 5.00 pm

ii. Visiting hours shall be determined by the Hospital management depending on the current health situation such as during the pandemic or any other government direction or order. Generally, the visiting hours shall be as follows:

Day	Time
Weekdays	12.30 pm - 2.00 pm 5.00 pm - 7.00 pm
Saturday, Sunday & Public Holidays	12.30 pm - 7.30 pm

iii. Special visiting hours apply to critical care areas such as the ICU, CCU, CICU, CRW, HDU, NICU and PICU. The visiting hours shall be as follows:

Day	Time
Weekends, Saturday, Sunday & Public Holidays	12.30 pm - 2.00 pm 5.00 pm - 7.00 pm

iv. During visiting hours, visitors shall be allowed to visit patients in the general wards except in the event of a pandemic.

v. Only one carer is allowed to accompany a patient at any given time.

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

vii. Children aged below 12 are not allowed to visit patients in the Hospital.

2.8.2 Outside Visiting Hours

i. There shall be no visitors outside visiting hours unless special permission is given by the doctor in charge. This visit shall not exceed more than half an hour. All visits after visiting hours shall be recorded.

ii. A relative may be allowed to accompany a patient subject to the approval of the ward staff. A special pass (*Pas Menunggu*) shall be issued to one person in the following situation:

a. Relatives who are allowed to accompany critically ill and bedridden patients.

b. Only same gender relative shall be allowed to accompany a patient after 9.00 pm.

c. The mother or guardian is allowed to accompany a child in the paediatric ward.

d. The mother of a baby admitted to the Special Care Nursery for breastfeeding purpose.

2.8.3 Other Hospital Visitors

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

ii. Members of the Board of Visitors with identification card shall be allowed to enter the Hospital at any time for formal duties.

iii. Very Important Persons (VIPs) on official visit shall be accompanied by the Hospital staff.

2.9 Stakeholder Relations

2.9.1 Information Counter

i. An information counter shall be made available during office hours to provide information, directions and assistance to patients and the public.

ii. Appropriately trained and suitable staff shall be placed at the counter.

2.9.2 Complaints

i. The Hospital management shall have in place a mechanism whereby client grievances or complaints shall be adequately addressed.

ii. The Corporate Communication Department shall be responsible for monitoring comments or complaints. Comments and complaints shall be notified to the Hospital Director and the relevant department/unit as soon as possible for further actions.

iii. A common source of complaints are:

- Verbal complaints consist of complaints received in person, through 3rd party, and via telephone communication.
- Written complaints received through letters, faxes, e-mails, feedback forms from the suggestion box, google doc, SMS blast and others.
- Mass media which are complaints received through newspaper, radio and television or social media.

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

v. All complaints received shall be registered, documented, investigated and appropriate action taken. A response shall be issued within 72 hours and a reply within 14 working days of receiving the complaint.

vi. The investigation report shall be submitted to the relevant authority within UiTM in 4 weeks or sooner depending on the complexity of the case. Independent inquiry report for medico-legal cases shall be submitted to the Hospital Director within 2 weeks.

2.9.3 Patient experience survey shall be carried out among patients in wards, ED, Daycare, Rehabilitation Services and Outpatient Clinic.

2.9.4 Suggestion boxes and QR code shall be placed at strategic locations to obtain feedback and comments from the public.

2.9.5 Release of Information

i. Subject to the practice direction and circulars issued by UiTM[27], the Hospital shall not make any statement on policy matters to the public or any media.

ii. Patient information shall not be released without prior approval (written consent) from the patient.

2.9.6 Photography/Filming/Interview

i. As recordings made for clinical purposes constitute part of a patient's medical record, they should be treated in the same way as any other part of the medical record.

ii. Prior consent must be obtained if the practitioner is planning to take clinical photographs or audio-visual/multimedia recordings. Refer to MMC guideline[28].

iii. Any media shall not be allowed to make any recording and interview with anyone including staff, patients and visitors in the Hospital without consent from the Hospital Director.

iv. Any commercial filming or drama shooting in the Hospital compound shall not be allowed without consent from the Hospital Director.

2.9.7 Public Forum and Exhibition

i. The Hospital may organize talks or exhibitions to provide health education to the public.

ii. Health promotional activities may also be organised to create public awareness and encourage public participation.

[27] Surat Pemakluman Mengenai Kenyataan Rasmi dan Pengendalian Majlis Universiti Teknologi MARA bertarikh 19 Oktober 2020 (Reference No : 100-UiTM (NC 6/2/1)
[28] Malaysian Medical Council Guideline. Reference - https://mmc.gov.my/laws-regulations/

2.10 Communication System

2.10.1 Telephone and Fax

i. The Hospital uses Private Automatic Branch Exchange (PABX) telephone system for in-hospital and out-of-hospital calls.

ii. There are three types of PABX telephone lines in the hospital. Type A-line allows calls to be made internally and externally including cellular lines. Type B-line allows calls to be made internally and externally excluding cellular lines. Type C-line can only make internal calls.

iii. Type A-line shall be made available for The Hospital Director as head of the organisation.

iv. Heads of the Clinical Department shall be provided with a type B line. Specific areas shall also be provided with a type B line. All other telephone lines within the Hospital shall be of type C.

v. Telephones shall be for official use only. Usage of telephone will be monitored by the operators.

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

vii. A two–way communication system shall be provided in the ambulances for communication between the ambulance and the base station in the ED.

2.10.2 Nurse Call System

i. A nurse call system shall be provided to all beds for patients to use when assistance is required. The system may be extended to patient areas such as washroom and toilets.

ii. Nurses shall attend to the patient as soon as possible when the nurse call system is activated.

2.10.3 Public Address System

i. The Public Address (PA) system shall be used to make announcements, alerts and provide information.

ii. The PA system may be used for emergencies using specific codes as stated in the Hospital Disaster Preparedness Policy.

2.10.4 Social Media

Current technology in various social media applications shall be adopted as means of communication and the use of official social media shall at all times adhere to the laws, regulations and circulars issued by UiTM[29].

2.10.5 SMS

Notifications through SMS including but not limited to an appointment, scheduling and patient queue shall be adopted as a mean of communication.

[29] Dasar Media Sosial Universiti Edisi 2016, Universiti Teknologi MARA

2.11 Transport System

2.11.1 General Transport System and Ambulances

i. The Hospital shall provide ambulance services for patients and transportation for both patients and staff. Ambulances and vehicles shall always be well maintained and ready for use.

ii. Hospital vehicles shall be used for specified purposes as follows:

- Ambulances shall be used for pre-hospital care and inter-hospital transportation of patients.
- Hearses shall be used for the transportation of dead bodies.
- Vans shall be used to transport supplies and materials.
- Mobile transport shall be used to transport staff and ambulant patient.
- Cars shall be used to transport staff.
- A lorry shall be used to transport bulky items such as furniture and equipment.

iii. Hospital vehicles shall be driven by Hospital driver with valid driving licenses and shall always abide by the road traffic rules and regulations at all times.

iv. Ambulance drivers are required to undergo specific training.

v. The ambulances shall be under the responsibility of the ED whilst the other vehicles will be under the responsibility of the Administration Department.

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

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

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

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

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

2.11.2 Pneumatic Tube System

i. The pneumatic tube shall be used to transport pathology specimens, medicines, documents and medical records, with weight according to the system specification. Items other than this are not allowed.

ii. Items shall be placed in the special container provided before being transported in the pneumatic tube.

iii. The department using the pneumatic tube (sender) shall be responsible for the proper and safe transfer of items and to trace the items in case of delay or non-arrival at the receiving end.

2.12 Traffic Control

i. The Hospital shall implement a traffic system within the Hospital to avoid traffic congestion. Route to the ED shall only be used by ambulances and public/private vehicles bringing emergency cases, for exit and entry.

ii. Drop-off and pick-up zones may be provided near the entrance to the Main Lobby, Specialist Clinics, Patient Assessment Centre (PAC), Obstetrics and Gynaecology (O&G), ED, Oncology Unit, Rehabilitation Department, Haemodialysis Unit and Surau for patient's convenience.

iii. Parking outside the designated parking areas shall be strictly prohibited.

Chapter 3:
Hospital Governance

Julina Md Noor, Mohd Amin Mohd Mokhtar, Fatim Zulaika Mohamed Ali, Mahfuzah Ruselan.

3.1 Board of Visitors

3.1.1 Hospital Board of Visitors

i. The Hospital shall establish a Board of Visitors as required by the MOH. The Board members shall be appointed by the MPH and appointed members shall be provided with an identification card.

ii. The Board of Visitors shall act as a link between the Hospital and the community.

iii. The Board members shall be briefed on the Hospital organisational structure and services, the rules and regulations and the Board of Visitors roles and responsibilities.

iv. Board members shall be allowed to make visits to the wards and other public areas during or after office hours. The Hospital management shall take appropriate actions on the feedback received or issues raised by the Board.

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

3.1.2 Hospital Volunteers

i. An individual or group who wants to become Hospital volunteers may apply to the Hospital and shall follow the procedure required for approval.

ii. A Medical Social Work (MSW) Officer or any officer from the Hospital may be appointed as coordinator. This person will be in charge of guiding the volunteers and monitoring their services.

iii. The Hospital volunteer shall abide by the Hospital rules and regulations and shall professionally render services.

3.2 Hospital Safety and Security

3.2.1 General Security

i. The different areas in the Hospital shall be identified either as high, medium or low-security risk. Examples of high-security areas are the entrances, stores, revenue unit, wards and delivery suites.

ii. Areas identified as high or medium security risk shall have security measures installed and security guards placed at all times. Other areas shall have regular site patrols by the security guards.

iii. Clear 'No Entry' signs shall be placed in areas and on doors to the rooms which are restricted for the staff or authorised personnel only.

iv. The department/unit heads are responsible for the security procedures within the department and staff compliance to the procedures.

v. Specific areas (as decided by the Hospital Director) shall have electronic surveillance and be centrally monitored.

vii. Entrance to all wards and departments shall be equipped with a mechanical control system or electronic system. Prisoners who are in-patients must be guarded at all times by prison wardens, subject to law and regulation[30]. The Hospital shall take full responsibility for the prisoners' custody during the stay in the Hospital.

viii. Patients who are subjected to police cases and prisoners must be accompanied by the relevant authority at all times in the Hospital.

ix. Subject to law and regulation, controlled drugs shall be stored in a dangerous drug act (DDA) cupboard[31].

3.2.2 Fire Safety

i. The Hospital shall appoint a Safety Officer and have a fire contingency plan in place.

ii. Appropriate fire equipment shall be made available in all areas and fire equipment regularly maintained.

iii. The person in charge of the respective areas shall ensure regular inspections are carried out on all firefighting facilities, fire-retardant doors and escape routes. The person shall also be responsible for the fire safety procedures and ensure that staff adhere to these procedures.

iv. Fire retardant doors are to be kept closed at all times but not locked. If exit doors need to be locked, the keys shall be made readily available.

v. In the event of fire, patients shall be evacuated following the principle of horizontal evacuation and if the fire continues to spread, to move vertically down.

vi. All staff shall receive training on fire safety, evacuation procedures and the use of firefighting equipment. Fire drills shall be conducted regularly, at least once a year.

3.2.3 Radiation Protection

i. The Hospital shall establish a Radiation Protection Committee chaired by the Hospital Director/Appointed Chairman.

ii. The Hospital shall appoint a Radiation Protection Officer (RPO) to oversee and coordinate activities related to radiation protection.

iii. Policies, procedures and guidelines on radiation safety and protection according shall be made available to all relevant department/unit.

iv. Briefing on the policies and procedures on radiation safety and protection shall be conducted for specific staff.

v. The radiation exposure of staff is routinely monitored including necessary blood count and medical examination.

[30] Section 40(1) of the Prison Act 1995 [Act 537].
[31] Dangerous Drugs Act 1952 [Act 234] Laws of Malaysia.

vi. Reference may be made to the following documents on radiation protection[32],[33],[34][35].

vii. Facilities and imaging personnel shall adhere to regulations and guidelines on the use of ionizing radiation[36].

viii. For women of childbearing age, the guidelines by the MOH shall be adhered to[37].

ix. X-ray equipment shall be operated by a radiographer.

3.2.4 Infection Control

i. The Hospital Infection and Antibiotic Control Committee (HIACC) shall be chaired by an Infectious Disease Consultant or Clinical Microbiologist assisted by an Infection Control Doctor and Infection Control Nurses.

ii. The HIACC may conduct the following:

- Formulate and review policies and procedures regarding Hospital-acquired infection and proper usage of antimicrobial therapy.
- Disseminate knowledge, improve skills and inculcate desired values in health care workers about the subject through education and training.
- Disseminate and ensure compliance with the policies and procedures among health care workers and (where applicable) patients, relatives and visitors.
- Plan out Hospital-wide infection control programmes and activities yearly. This function is incorporated in the day-to-day activities of personnel, patients and visitors..

iii. The Ward Sister or senior staff nurse shall be the infection control link nurse for the respective ward/unit/department.

iv. All Infection control nurses shall have Ministry of Health Post basic training.

[32] SPKPK Bil. 10/2002 Panduan Tatacara Pengendalian Filem X- Ray Di Hospital- Hospital dan Klinik Kesihatan Malaysia, 14 October 2002.
[33] SPKPK Bil.9/1994 Guidelines and Action Plan on Management Of Radiation Emergencies, 28 November 1994.
[34] SPKPK Bil.10/1987 Penggunaan Mesin X-Ray MMR di Hospital- Hospital, 6 October 1987, (iv) SPKPK Bil.6/1986 Menghadkan Penggunaan Mesin X-Ray Jenis Mobile/ Portable untuk Kegunaan Radiologi di Wad-wad, 25 Mac 1986.
[35] Atomic Energy Licensing (Basic Safety Radiation Protection) Regulations 2010.
[36] Atomic Energy Licensing Act 1984 (Act 304) LPTA, BSS 1988, MS 838).
[37] Radiology Information System, Health Informatics Standard, MOH, KPK (2) dlm. KKM-153 (13/3) Bhg. 9 1998

Chapter 4:
Clinical Governance

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4.1 Patient-related Policies

The Hospital shall at all times observe the rights of patients and deliver service to patients in accordance with the laws and regulations issued by the Malaysian Medical Council which includes but not limited to the following[28]:

A. Ethical Codes:

i. Code of Professional Conduct

ii. Good Medical Practice

iii. Credentialing

iv. A Guidebook for House Officers

v. Guidelines for Medical Practice for Doctors Beyond the Age of 70 Years

vi. Expert Witness

vii. Standing Orders for the Conduct of Inquiries at the Preliminary Investigating Committee Level and at the Council Level (Medical Act 1971)

viii. Standing Orders for the Conduct of Inquiries of the Malaysian Medical Council (Medical Act 1971 (Amended 2012))

ix. Guidelines On The Ethical Aspects Of Aesthetic Medical Practice

x. Confidentiality Guidelines

xi. MMC Guidelines for Good Dispensing Practice

B. Ethical Guidelines:

i. Guidelines on Consent

ii. MMC Guideline on Plagiarism

iii. Brain Death

iv. Clinical Trials & Biomedical Research

v. Good Clinical Practive

vi. Dissemination of Information by the Medical Profession

vii. Ethical Implications of Doctors in Conflict Situations

viii. Medical Genetics & Genetic Services

ix. Medical Records & Medical Reports

x. Organ Transplantation

xi. Relationship between Doctors & the Pharmaceutical Industry

xii. Assisted Reproduction

xiii. Stem Cell Research & Stem Cell Therapy

[28] Malaysian Medical Council Guideline. Reference - https://mmc.gov.my/laws-regulations/

xiv. Managing Impaired Registered Medical Practitioners

xv. Audio & Visual Recordings

xvi. Restriction on Practice of Ozone Therapy & Chelation Therapy

xvii. MMC's Position on Managed Care Practice

xviii. HIV & Blood Borne Virus Infections Guidelines

4.1.1 Patients' Rights

i. A patient has the right to receive a holistic approach to patient care, including health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services.

ii. Information regarding the relevant policies, rules and regulations of the Hospital shall be made available including quality and performance improvement of the Hospital.

iii. No patient shall be discriminated against race, gender, sex, religious belief, social and economic status or on any other factors.

iv. The Hospital shall respect the patients' rights inclusive of the cultural, spiritual and religious belief of the patient and families.

v. The Hospital shall be responsible for the safety of the patient during the Hospital stay.

vi. Medical care shall be given in a considerate and respectful manner and information about the medical care be kept confidential.

vii. The Identity of the healthcare providers and caregivers involved in the patient's treatment shall be made known.

viii. Treatment shall be given based on patients' clinical condition. Treatment provided to patients is individualised for the disease and given safely.

ix. Healthcare providers shall listen and respond promptly to patient's report of pain and manage pain appropriately.

x. The Hospital shall communicate with the patient and family on the disease condition and the treatment options available including the right to a second opinion.

xi. The patient and family will be involved in all decision making. Any decision made by the patient and family shall be respected including refusal to treatment and Discharge Against Medical Advice (DAMA).

xii. Appropriate counselling shall be given to the patient and family members prior to DAMA.

xiii. Relevant information on the organ procurement, donation and transplantation process shall be made available where necessary.

i. The Hospital shall make available the approximate cost of treatment to the patient prior to the provision of care and provide an itemised statement of charges upon discharge. Information regarding financial and other assistance that may be available will be provided to the patient.

ii. Patient with hearing/speech impairment and language barrier have the right to request an interpreter.

xvi. Children, disabled individuals, the elderly and other population at risk has the right to receive appropriate protection while receiving treatment at Hospital. This includes comatose patients and individuals with mental or emotional disabilities. Such protection extends beyond physical injury to other areas of safety such as protection from abuse, negligent care, withholding of services or assistance in the event of an evacuation. The above group of patients will be provided special amenities to meet their needs, e.g. special lane, disabled-friendly toilets, children's toilets and sink, etc.

xvii. A patient and his/her family shall have the access to an appropriate grievance redress mechanism.

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

xix. Appropriate and relevant consent shall be obtained from patients who are involved in medical research, investigations or clinical trials. Patients and families will be given the following information:

- Expected benefits
- Potential risks and complications
- Procedures that shall be followed
- Obtaining informed consent
- Withdrawal from participation
- Suspension or termination of the research

4.1.2 Patient's Responsibilities

A patient shall:

i. Be cooperative and participate in the treatment and medical care provided by the Hospital.

ii. Observe appointments and treatment programmes provided by the Hospital.

iii. Provide accurate and complete information to the Hospital including the use of traditional medicines.

iv. Furnish payments of Hospital bills including any costs associated with treatment and services received in the Hospital.

v. Be responsible for the patient's own informed decisions.

vi. Maintain personal conduct and behaviour at all times so as not to interfere with the well-being of other patients or providers of healthcare.

vii. Be responsible to maintain his/her health.

viii. At all times, abide by the rules and regulations of the Hospital.

ix. Treat all Hospital staff, other patients and visitors with courtesy, respect, mindful of noise levels, privacy and number of visitors.

x. Speak up and ask questions when he/she do not understand information or instructions.

xi. Be fully responsible for outcomes if the patient does not follow the care and treatment plan provided by the Hospital.

xii. Be considerate of Hospital facilities and equipment and use them in such a manner so as not to abuse them.

4.1.3 Consent

i. Every patient has a choice whether or not to undergo a proposed procedure, surgery, treatment or examination. Informed consent usually refers to the idea that a person must be fully informed and understand the potential benefits and risks of their choice of treatment. An uninformed person is at risk of mistakenly making a choice not reflective of his or her values or wishes.

ii. Obtaining a patient's consent is a specific legal requirement for certain procedures and is a part of good medical practice.

iii. The consent shall be obtained from the patient or next-of-kin prior to carrying out any clinical procedure. The consent shall be obtained from the patient if he/she is 18 years old or more and if he/she is physically and mentally competent.

iv. In a live-saving situation where all efforts to trace relatives and next-of-kin have failed, the Hospital Director and two clinical specialists who are from the related discipline may give consent for the procedure to be carried out. The consent and efforts made to trace the relatives/ next-of-kin shall be documented in the case notes.

v. All consent must be taken by a Medical Officer (MO) 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

vi. For patients below the age of 18 years, consent shall be obtained from the parent or legal guardian.

vii. Consent must be obtained from the patient or next-of-kin when body parts or organs are taken for academic or research purposes.

viii. For patients having mental illness who is required to undergo surgery, electroconvulsive therapy or clinical trials, consent for any of them may be given by:

- The patient himself if he/she is capable of giving consent as assessed by a psychiatrist;
- His/her guardian, in the case of a minor
- A relative in the case of an adult, if the patient is incapable of giving consent;

ix. Two psychiatrists, one of whom shall be the attending psychiatrist, if there is no traceable guardian or relative of the patient and the patient himself/herself is incapable of giving consent.

x. For a patient below the age of 18 years who require medical treatment, consent shall be obtained as follows:

- If in the opinion of a treating doctor, 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;
- If the treating doctor 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: -

    a. That the parents/guardian of the child/any persons having the authority to consent to the treatment has unreasonably refused to give or abstained from giving consent to such treatment;

    b. 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;

    c. The Protector believes on reasonable grounds that the parents/guardian/the authorised 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 Ministry of Health, the Deputy Director-General Ministry of Health, a Divisional Director of Social Welfare, Department of Social Welfare, the State Director of Social Welfare of each of the State, and Social Welfare officer appointed[38].

[38] Child Act 2001 (Act 611) Laws of Malaysia

4.1.4 Counter Services

i. The Hospital shall have a general information counter and dedicated counters e.g. registration counters, clinic counters, ward counters etc. and the functions include:

- Providing information
- Providing assistance
- Receiving suggestions or complaints

ii. The counter shall be manned by competent persons.

iii. A senior staff shall supervise the effective delivery of related counters.

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

v. Priority Lane at the registration counters shall be provided to the following clients (except in ED):

- Children aged two years and below
- Senior citizens (60 and above)
- Blood donors (according to existing guidelines)
- Disabled persons *(Orang Kelainan Upaya)*
- Persons in custody *(Orang Kena Tahan)*
- Organ donors

4.2 Appointment and Scheduling

i. Appointment may be made by phone, email, letter or personally at the clinic.

ii. Services shall be given on an appointment basis except for the ED.

iii. Early rescheduling of appointment shall be upon approval by the relevant department or according to the policy of the department/unit as approved by the Hospital management.

iv. All clients shall be informed of the relevant document/item to facilitate the registration process e.g. referral letter, appointment card and Letter of Guarantee (e-GL) etc.

4.3 Registration

i. Each patient shall have only one medical record number (MRN) for personal identification.

ii. Children below the age of 12 years shall be registered using MyKid/Birth Certificate/ Passport.

iii. Registration format shall be as specified by the Hospital management. The staff at the registration counter shall be responsible for ensuring the completeness of the information and no duplication.

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

v. Without proof or evidence of the method of payment (Guarantee Letter/ Exemption/ Pensioner/Insurance etc.) patient will be classified as a self-paying patient.

vi. Identification of a newborn shall use his/her mother's Mykad/passport/other ID number plus prefix "D" followed by a sequence of delivery. For example, a second baby born to a mother with Mykad number: 800417035646 shall be identified as 800417035646 D02.

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

viii. Registrations for: Birth Before Arrival (BBA)/Birth in Ambulance/Birth in other vehicles:

- The transporting ambulance shall reroute to the nearest health facility and registration shall be done at the facility (public/private).
- If the umbilical cord is cut by Hospital staff, it is considered a Hospital birth.
- In Hospital statistics, the location of this birth is considered BBA with the name and Mykad of staff attending to the delivery recorded.

ix. In circumstances whereby a patient is already registered at Inpatient Registration, and deteriorate during the journey to the ward or OT, there will be two possibilities:

- If the patient is still near the vicinity of ED, the patient shall return to ED, and if death occurs, it shall be an ED statistic death. The admission shall be cancelled in the system with justification.
- If the patient is nearer to the ward, he/she shall be wheeled to the ward, and it will be the ward statistic death if the patient succumbed.

x. Registration for an unknown individual is processed as a normal patient with temporary identification/ information given. Information will be updated once verified details are given by the patient/ next of kin. Format for temporary information of an unknown patient is as follows:

- Name: Unknown or XYZ
- Gender: Male/ female

xi. If information of an unknown patient is not available, a police report shall be made.

xii. During system downtime, manual pre-printed forms must be used for registration purposes. After downtime, all manual registration shall be keyed into the system.

4.4 Consultation

i. The Hospital shall ensure the safety, confidentiality and privacy of the patients throughout consultation and examination.

ii. Patients at the Specialist Clinic shall be managed by the doctor relevant to the particular illness/speciality.

iii. The assessment of patients shall be documented in the designated clerking forms comprising a full medical history and physical examination.

iv. Nursing assessment and entries by other allied health personnel shall be documented in the patient's case notes as integrated case notes.

v. Examination of a patient by a doctor of a different gender must be done in the presence of a chaperone. Examination of a child must be accompanied by parents or caretaker.

vi. Medical students are allowed to be present during the consultation. However, patients have the right to refuse the presence of medical students.

4.5 Admission

4.5.1 Patient Admission Flow

i. The patient's admission formalities shall be carried out by the Admission Unit.

ii. Stable patients from the referring hospital/health clinic can be admitted directly to the relevant ward after consultation with the ward doctor/ Specialist on call.

iii. All unstable patients shall be optimized in the ED before admission to the ward. Direct admission to the Intensive Care for the very ill patient shall be arranged with prior consultation and agreement by the anaesthetist/ intensivist in charge.

iv. Maternity cases (24 weeks and above) shall be sent directly to the Patient Assessment Centre (PAC) and the necessary admission formalities attended to subsequently.

v. Patients or their relatives shall pay a deposit or produce a Letter of Guarantee on admission in accordance with the fees schedule.

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

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

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

4.5.2 Bed Management

i. Overall management of beds shall be the responsibility of the Bed Management team headed by a Bed Manager.

ii. There shall be a Bed Management Committee to oversee the mobilisation of bed, especially during access block.

iii. Paediatric patients below 12 years of age shall be admitted to the Paediatric ward. Paediatric patients between 12 to 16 years of age shall be admitted to the adolescent ward.

iv. The adolescent ward is for:

- Chronic illnesses of up to age 16 and under paediatric follow up.
- Multidisciplinary surgical patients of up to age 12.

v. No allowance shall be made for additional or temporary beds in the wards. In the event where the ward is full, patients are temporarily admitted to an appropriate or related ward until the availability of a bed.

vi. If a patient cannot be admitted to a designated ward due to the unavailability of a bed, the patient can be lodged to another ward except to O&G and Paediatric Wards.

vii. If no beds are available in the wards, arrangements shall be made to transfer the patient to another hospital.

viii. If O&G and Paediatric wards are full, O&G and paediatric patients cannot be lodged to other wards and arrangements shall be made to transfer patient to another hospital.

ix. Discharged patients shall vacate the bed on the same day of discharge. Discharged patients that meet the criteria will be transferred to the discharge lounge.

x. Bed swapping and transfers shall be documented in the Electronic Medical Record (EMR) by the ward staff.

4.5.3 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 or MRN given.

ii. All valuables belonging to these groups of patients shall be kept in an envelope sealed, named, dated and witnessed by 2 medical personnel.

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

4.5.4 Admission to VIP or Executive Ward

i. The decision to admit a patient to the VIP or Executive Ward shall be determined/verified by a Specialist according to the clinical condition.

ii. When a patient's clinical condition becomes unstable and requires intensive care, the patient shall be transferred to HDU/ICU/CCU and the bed shall be vacated. Patient on the waiting list can then be admitted to occupy the bed.

iii. When there is no available bed in the VIP or Executive Ward, the patient shall be admitted to the general ward and placed on a waiting list for the VIP or Executive Ward. The transfer shall be made when a bed is available.

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

4.6 In-Patient

4.6.1 In-patient Ward

i. An identification wristband shall be provided to all inpatients and must be worn at all times during the Hospital stay.

ii. Assignment of beds shall be done by the team leader of the ward. Patient of the same gender shall be admitted to the same room or cubicle.

iii. The attending Nurse shall inform the doctors within 15 minutes of a new patient admitted; stable patients shall be seen by a doctor within 60 minutes.

iv. An individual patient shall be provided with a bed, chair, locker and Hospital garments. Facilities like toilet, bath and rest area shall be shared.

v. All patients/caretaker shall be given an orientation on the Hospital which includes information about housekeeping, ward and Hospital facilities, plus safety instructions by the ward staff.

vi. Patients are advised against wearing jewellery or bringing along valuable items including a large amount of cash for admission. The patient shall be advised to immediately hand over the valuables to the next-of-kin to bring home for safekeeping.

vii. In-patients shall be reviewed at least twice a day by a MO and once a day by a specialist. Additional reviews when necessary will be according to the patient's clinical condition.

viii. The use of cell phone is permissible, however charging will be done at designated areas.

ix. Patients and/or relatives are not allowed to take pictures or videos in the ward.

4.6.2 Seriously Ill Patients/Death in Line (DIL)

The 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. The details of the discussion shall be documented in the patient's case note.

4.6.3 Do Not Resuscitate (DNR)

i. If a patient is deemed seriously ill, a discussion regarding the goal of care shall be made between the Consultant/Specialist in charge from the primary team and Consultant/Specialist from other disciplines involved in the care of the patient with the patient's family.

ii. The goal of care discussed shall be explained to the patient's family and agreed upon.

iii. If the decision to "Do not resuscitate" has been agreed upon, it must be documented and signed by the consultant/specialist in the patient's case note and the DNR form be completed.

4.7 Discharge

All discharges shall have a Discharge Summary which includes diagnosis, medication and management plan. The ICD 10 coding for diagnosis and ICD 9 for a procedure should be stated upon discharge. Every patient shall be issued a bill of service at discharge.

A discharge package (summary, bills, medications, MC, follow-up appointment, health information, patient experience survey etc.) shall be given to the patient prior to discharge.

4.7.1 Planned discharge

i. The MO/Specialist in charge of the patient shall be responsible for communicating information about planned discharge at least 24 hours prior to the event.

ii. Identification wristbands for adult patients shall be removed in the ward upon discharge.

iii. Identification wristbands for newborn and paediatric cases shall be removed by the auxiliary police/security at the Hospital lobby.

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

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

vi. A diagnosis shall be made before a patient is discharged. Doctors have to complete and provide the Discharge Summary to the patient.

vii. If the patient requires to follow up at the community level (General Practitioner, *Klinik Kesihatan*, Primary Care Medicine Clinic), a letter of referral shall be provided to the patient.

viii. All discharged patients must settle their bills in accordance with the fee schedule.

ix. Malaysians and Non-Malaysians who are unable to settle their bill due to financial reasons will be referred to the Medical Social Department/ Revenue Unit/Hospital administration.

x. Planned discharge should be done between 8 am till 9 pm.

4.7.2 Discharged Against Medical Advice (DAMA)

i. All patients requesting to be discharged against medical advice can do so after obtaining adequate explanation and clarification from the MO/Specialist in charge.

ii. The DAMA discharge form has to be completed by the MO in charge and signed by the patient/relatives/guardian and a witness. DAMA forms shall be retained at the Patient Record Department.

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

4.7.3 Absconded patient

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

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

iii. If the patient remained missing after 24 hours, a police report shall be lodged and the patient is considered to have absconded. If a patient remained missing after 24 hours, the patient shall be removed from the census.

4.7.4 Dismissal of Patients From System

i. The system will automatically discharge a patient from the clinic at 00:00 hours (at midnight). The exception to this is the ED.

ii. For in-patients, a similar function is made available for patients who have been discharged on the same day.

4.7.5 Discharge to Other Hospital

i. Discharges to other Hospital are allowed based on discussion and agreement between the referring and receiving Hospitals.

4.7.6 Discharge Dead

i. The movement of a deceased patient shall be made to the mortuary and discharged from the mortuary.

4.7.7 Discharge Diagnosis

i. Discharge diagnosis/diagnoses are made mandatory in the EMR upon discharge from the Hospital or facility. These diagnoses shall be in free-text documentation. Diagnoses shall be classified into principal diagnosis, secondary diagnoses, co-morbidities etc.

4.7.8 Cancellation of Discharge

i. Cancellation of discharge before midnight is permitted in specific conditions:

- Clerical error e.g. the wrong person discharged or transcription error.
- Unexpected change of patient condition.
- The issue of logistic.
- Cancellation shall be performed by authorised personnel in the ward. A request needs to be made to the authorised personnel (Information Technology Officer).

4.8 Death

4.8.1 Death at Hospital

i. The attending doctor in the ward or the ED shall carry out confirmation of death. Patients who died in the Hospital shall be transferred to the mortuary accompanied by Hospital personnel within one hour of confirmation of death.

ii. On confirming death, the ward/department staff shall verify whether the deceased is a pledged organ donor. If yes, the staff shall notify the mortuary and contact the next-of-kin. If the next of kin is not contactable, the police shall be notified.

iii. The attending doctor, on confirming the death of a patient, shall register the death using the forms *"Perakuan Pegawai Perubatan Mengenai Sebab-Sebab Kematian JPN. LM9 or LM10"* and *"Daftar Kematian/Permit Mengubur JPN.LM02 (Pin. 1/11)"*. House Officers shall not be allowed to sign the above documents.

iv. The body of the deceased must be tagged with a body tag bearing the identity of the deceased, a white tag for non-medicolegal and a blue tag for medicolegal cases.

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 a referred patient, the Hospital shall be responsible for body release to the next-of-kin or autopsy, if necessary.

vii. Unclaimed bodies (non-medicolegal cases) shall be notified to the police immediately. The body shall be handed over to the respective religious body for burial or cremation if no claim is made after 3 days for Muslim and 14 days for non-Muslim.

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 complied in accordance with the existing policies and practise guidelines to prevent cross-infection[39],[40][41]. Environmental Health Officer or Assistant Environmental Health Officer from the Environmental Health & Sanitation Unit shall be informed.

x. Subject to fulfilment of criteria and relevant procedures imposed by the Hospital, unclaimed bodies shall be handed to the Faculty of Medicine UiTM for the purpose of education and research. For avoidance of doubt, reference may be made to *Garis Panduan Penyerahan Mayat tidak dituntut di Jabatan Perubatan Forensik HUiTM kepada Fakulti Perubatan UiTM bagi Tujuan Pendidikan dan Penyelidikan.*

xi. Any patient who dies in the Hospital shall be transferred on a cadaver trolley to the mortuary by the mortuary attendant and accompanied by the ward attendant. Relatives are allowed to accompany the body.

xii. The hearse shall be used upon request to transport the deceased from the Hospital to the agreed destination subject to availability of vehicles, drivers and fee.

[39] Garis panduan Pengimportan Atau Pengeksportan Mayat Atau Mana-Mana Bahagiannya Edisi Pertama Moh/K/Epi/ 2006
[40] Policies and Procedures on Infection Control, Ministry of Health Malaysia, Second Edition, 2010
[41] The Disinfection and Sterilization Policy and Practice 2002, Ministry of Health

4.8.2 Brought-in-dead (BID)

i. All BID cases brought by the police shall go directly to the mortuary.

ii. BID cases brought by families/public shall be seen and registered in ED 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 that require Crime Scene Investigation (CSI) as requested by the police, the AMO on duty shall inform the Forensic Pathologist on call immediately.

v. The body shall only be released after all the relevant procedures and documentation is completed in accordance with the stipulated guidelines.

4.8.3 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 medico-legal/police cases, death should be reported to the police and post mortem order will be issued by the Investigating Police Officer.

iii. Post mortem shall be performed by the Forensic Pathologist or MO from the Forensic Department depending on the complexity of the cases.

4.9 Referral System

4.9.1 General

i. Transfer of patients may occur routinely or as part of a regionalised plan to provide optimal care for patients at more appropriate and/or specialised facilities.

ii. Referral of patients between Hospitals can occur from a lower to a higher level of care, higher to a lower level of care and also at the same level of care depending on the needs of the patients and/or the providers of care.

iii. The Hospital shall develop pre-existing transfer arrangements between the facilities and pre-transfer communication between the appropriate persons to facilitate the efficient flow of continuum of care to the patient.

4.9.2 Inter-departmental (In-patient) Referral

i. Inter-departmental in-patient referrals shall be seen in the patient's respective ward (unless a special procedure is required).

ii. Referrals shall be made with the approval of the attending Specialist/ Consultant.

iii. Referrals shall be duly seen by the MO/Specialist/Consultant.

iv. Referrals shall be made online and followed by a courtesy call.

v. Urgent referrals shall be seen within 6 hours or sooner, depending on the level of acuity.

vi. Non-urgent referrals shall be seen within 24 hours of the referral.

4.9.3 Inter-departmental (Outpatient) Referral

i. Referrals to the Specialist Clinics shall be done through the scheduling/ appointment system.

ii. Referrals shall be in a specified format and provide details of history, clinical examination, treatment and reasons for the referral.

iii. Referrals to sub-specialty clinics shall be according to the criteria for referrals or admissions agreed upon by all departments.

4.9.4 Incoming External Referrals (Outpatients) Referral

i. External referral includes referral from GP, KK, PPUiTM Selayang.

ii. Referral to ED will be triaged to determine the stability of the patient, urgency of the referral and appropriateness to the department being referred.

iii. Referral to Specialist Clinic shall be assessed by a staff nurse/medical assistant assigned at the clinic counters during office.

iv. Appointments for referrals shall be made at the main registration counter of the Specialist Clinic either through a telephone call, email or by the patient presenting with relevant referral documents.

v. All urgent referrals for radiology procedures shall be through a primary team in the Hospital.

vi. Scheduling of patients for investigation and consultation, where possible shall be made on the same day.

4.9.5 Emergency Department Referral

i. For unstable patients, referrals shall be made between the ED Specialist and the receiving department's Specialist.

ii. For stable patients, referrals shall be made between the MOs.

iii. ED referrals must be seen by the MO.

iv. Patients at the resuscitation zone shall be seen within 15 minutes.

v. Patients at the immediate care zone shall be seen within 60 minutes of referral.

vi. Non-urgent patients shall be seen within 90 minutes.

4.9.6 Intra-Facility Transfer

i. All unstable patients shall be accompanied by trained personnel including MO during transfer.

ii. All critically ill patients and those requiring assisted ventilation from ED may be admitted directly to the critical care ward after consultation between the specialist and anaesthetist-in-charge of the intensive care ward.

iii. Both referring and admitting Specialist/Consultant shall agree on the transfer decision.

iv. A patient shall only be transferred to another ward upon approval by the specialist.

v. All transfers including bed swapping shall be documented into the Hospital Information System (HIS).

vi. Patients and next-of-kin are to be informed of the transfers.

vii. Patient's/family's request for transfer to a different bed category shall be accommodated upon the availability of bed and affordability.

4.9.7 Inter-Facility Transfer

i. Patient transfer is a doctor-to-doctor referral.

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

iii. The primary team must contact the relevent Mo/specialist at the receiving Hospital to discuss the necessity of transfer of a patient. The receiving MO/ Specialist must agree to accept the patient before the transfer takes place.

iv. The patient's next-of-kin shall be informed about the process of transfer. In emergencies when a patient is unable to agree to transfer, and the next-of-kin is not contactable, the auxiliary police shall be informed to help in contacting them. The responsibility for transfer rests on the MO/ Specialist in charge of the patient and the consent of the relatives is not always required.

v. All patients shall be stabilised and deemed stable before transfer.

vi. The staff accompanying referred cases shall be decided by the MO or specialist in charge, after consultation with the receiving Hospital.

vii. All critical patients shall be accompanied by paramedics trained in resuscitation and led by a MO of the referring team. Accompanying staff for other cases shall be decided by the MO/Specialist in charge based upon the clinical condition of the patients. Continuous monitoring of patients shall be done and recorded accordingly.

viii. Documents pertaining to a patient's condition shall be made available to facilitate the transfer. This includes a referral letter with a detailed history of the patient and the reason for referral. All related radiological images and other investigation results (e.g. blood results) shall be included.

ix. A patient may be referred to the ED or directly to the appropriate ward/care unit. The accompanying team must be from the primary team and shall have clear instructions as to their exact destination (e.g. which ward to go) before arrival at the receiving Hospital to avoid delay.

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

xi. If the patient's clinical condition deteriorated during the transfer and resuscitation is required, the ambulance may divert to the nearest health facility or directed immediately to the ED of the receiving Hospital.

xii. If death occurs during the transfer, it shall be certified by a MO and the body shall be brought back to the referring Hospital.

xiii. Patients requesting self-transfer to other centres shall be informed of the risk by the attending doctor/specialist. The Hospital is not responsible for making transfer arrangement for self-transfer patients.

xiv. Patient on self-request transfer must sign the DAMA form and given a discharge note.

4.10 Medical Records and Documentation

4.10.1 Creation of Electronic Medical Record (EMR)

i. EMR shall be created upon registration of patients in the Hospital.

ii. Clinical management of all patients inclusive of data and images shall be entered in the EMR of the HIS by healthcare providers.

iii. Documentation of clinical care/data entry shall be maintained by Hospital personnel attending to the patient and each entry is captured in a real-time manner.

iv. Data entry is to be keyed–in by the healthcare provider or flowed in automatically from other systems/application. Cut and paste function as a new data entry is possible upon the following conditions:

- The original source of information is being mentioned
- The original author is named
- Date and time of "copy and paste" activity stamped.

v. Cut and paste function is not allowed for House Officers.

vi. All supporting systems i.e. Laboratory Information System (LIS), Radiology Information System (RIS), Picture Archiving Communication System (PACS) etc shall be integrated into the main HIS.

vii. EMR is accessible in the system for those with access rights until 72 hours after visit or discharge.

4.10.2 Summaries in Electronic Medical Record

There shall be two types of summaries depending on the services rendered which is Encounter Summary and Discharge Summary. Accurate International Classification of Diseases (ICD) Coding shall be used for diagnosis.

A. Encounter Summary

i. Encounter Summary is defined as a summary made at the end of every encounter by the Health Care Provider in the outpatient setting.

ii. Encounter Summary shall be prepared once the patient has completed seeing the Health Care Provider such as in ED, Day Care Services, Specialist Clinics, Rehabilitative Clinics, Dietetic Clinic, etc.

iii. Encounter Summary is auto-generated once the healthcare provider discharges the patient. The defined content shall be auto-populated in the Encounter Summary. Before submission of the Encounter Summary, the healthcare provider shall confirm the content of the Encounter Summary and able to edit wherever necessary, except for the demography information.

iv. Encounter Summary shall be completed within 24 hours.

v. A MO shall verify the Encounter Summary if it is prepared by the House Officer (HO).

B. Discharge Summary

i. A Discharge Summary is defined as a summary of the patient illness and management rendered to him/her during the episode of stay in the Hospital.

ii. A Discharge summary shall be prepared by the doctor once a patient is discharged from the ward regardless of the type of discharge.

iii. Types of discharges are:

- Discharged home
- Death
- Absconded
- Discharged against medical advice (DAMA)
- Transferred out

iv. A MO shall verify the Discharge Summary if it is prepared by the House Officer.

v. The doctor from the discharging discipline shall prepare the final Discharge Summary.

vi. The doctor shall ensure completeness of Discharge Summary by entering (key-in) Principal Diagnosis, Secondary Diagnosis, Co-morbidities, Complications etc.

vii. The Discharge Summary of a deceased patient shall be prepared using a similar format of Discharge Summary; however, information regarding death is made available.

viii. Discharge Summary can be accessed following Hospital User Access Control Policy (UACP).

4.10.3 Access and Sharing of Electronic Medical Record (EMR) in Hospital Information System

i. In digital technology, there are rules pertaining to access and retrieval of records. This can be referred to the UACP and existing law and regulation[42].

ii. Data may be accessed and shared between HUiTM facilities.

4.10.4 Principles to Sharing of Data

i. Confidentiality of patient data is of utmost importance and shall be strictly observed at all times.

ii. Data sharing is the responsibility of the healthcare provider. He/She must weigh the benefits and risks of sharing data of the patient, the health care provider and the organisation (stakeholder/ institution/ Hospital).

4.10.5 General Conditions for Access of Electronic Medical Record in a Facility

i. In general, EMR can only be accessed in the following conditions:

- When the patient is admitted to the hospital.
- When the patient is referred to the hospital.
- In certain cases, under the jurisdiction of the director of the facility, e.g. Updating national registry or quality initiative activities.
- For coding by medical record officers or other authorised personnel
- Case to case basis, upon need-to-know for clinical or research purposes, only for registered medical personnel or authorised personnel and can be audit trailed and monitored by infostructure department.

ii. Printing of any part of the EMR shall not be allowed except for referral purposes. Printing of the EMR shall be allowed if required by the law. Printing of any part of the EMR shall be done in the Patient Information Office. However, referral letter/ consent forms/ specified identified documents can be printed in the ward or clinic.

iii. The Hospital Director is responsible to determine the access of VIP and medico-legal cases.

iv. The Custodian to the EMR shall be the Patient Information Department. However, access control of the EMR is under the purview of the Infostructure Department as Information Technology (IT) Administrator.

v. For an inactive user of more than six (6) months, access shall be denied by the Infostructure Department.

4.10.6 Purpose of Access

i. Access for Continuity of Patient Care.

- EMR can be accessed by officers in the attending department.

[42] Personal Data and Protection Act 2010 [Act 709] Laws of Malaysia

- Clinical Support Service Officers e.g. Diagnostic Imaging, Pathology, Rehabilitation, Physiotherapy, Dietetics and Pharmacy, can access demographic and clinical data of patients who receive consultation in their disciplines.
- Access to EMR shall be deactivated after 72 hours (working day) of patient discharge from in-patient services and after 24 hours (working day) of out-patient services.

ii. Access for Research and Study Purposes

- Access to data in HUiTM facilities is allowed with written approval from the Hospital Director. The Hospital Director can appoint an officer for access right approval.
- Clinical related research involving patient care shall obtain approval from Research & Ethics Committee, and audit-related research shall obtain approval from Hospital Audit Committee

iii. Internal Customer

- For internal customers, data can be extracted through the Reporting Module in HIS.
- EMR access shall be made under the name of the applicant.
- Only specific approved EMR can be accessed by the requestor.
- The validity period of access rights is given upon request by the applicant with approval from the Hospital Director.

iv. External Customers

- External customers are defined as those who are not working at the facility. External customers must include UiTM staff as a member in the research or study project.
- External customer needs written approval from the Hospital Director.
- Temporary access shall be given to the requestor by the system administrator.
- Access duration will depend on the Hospital Director's approval in the facility.
- Access rights should be automatically disabled once the research ends.
- Students may be given access with approval by the Hospital Director but are restricted to view only.
- External customers need to comply with the research guidelines endorsed by the Hospital Medical Research and Ethics Committee.
- Information sharing between the Ministry of Higher Education and other governmental agencies is allowed with mutual agreement.
- The respective agencies or institutions shall have an MOU/MOA/NDA before data sharing.

4.10.7 Amendment of Electronic Medical Record

i. An amendment is defined as any changes made to the original record e.g. addition, deletion and substitution.

ii. In EMR, all amendments shall be made through soft delete (strikethrough) and a new entry shall be keyed-in in italic next to it. The system shall show the date and time of changes made.

iii. The system shall not allow cut and paste functions for amendment purposes.

iv. Amendments can be performed within 72 hours of discharge.

v. Any amendment deemed necessary after 72 hours of discharge needs approval from the Patient Information Department with permission by the HOD. A grace period of 14 days is permitted for amendments to be made.

4.10.8 Addendum of Electronic Medical Record

i. An addendum is defined as any form of data or images added to the EMR.

ii. Reasons for addendum are inclusive of but not limited to update of investigation results, the addition of Medical Certificate (MC) and referral letter.

iii. There is no time limit for an addendum to be done.

iv. There is no limit in terms of the quantity of addendum to be made.

v. The system should capture and display the person who made the addendum, date and time performed.

vi. The system shall also capture and display the reason for an addendum.

vii. There shall be no amendment allowed for Encounter Summary or Discharge Summary. However, an addendum is allowed to the Encounter Summary or Discharge Summary which provides data to be added to the primary document before the Encounter Summary or Discharge Summary.

4.10.9 Hospital Information System

i. HIS shall be an enabler of EMR that allows better sharing and record keeping.

ii. Staff who have been granted access to patient medical records shall follow the policies and laws that govern the use and disclosure of patient medical records. The level of access in HIS is given following rules and User Access Control Policy.

iii. All staffs can be accountable for any medico-legal matter from incomplete documentation in HIS. The Hospital Director, Infostructure Department and the Patient Information Department shall actively monitor the accuracy and relevancy of information in HIS.

iv. Any external request to access the patient record shall be made in writing to the Hospital Director to ensure confidentiality of the patient medical record.

v. Students or private practitioners shall not be given direct access to HIS. However, restricted access may be given with the approval of the Hospital Director according to ICT Policy.

vi. Recent advancement of technology allows the use of BYOD (Bring Your Own Device). Usage shall abide by the policy of BYOD.

4.10.10 Management of Medical Records and Report

A. Medical Record

i. Every patient receiving care in the Hospital shall have an individual medical record in the EMR.

ii. The care given and procedures done on a patient must be documented in the patient's medical record. The attending doctor shall be responsible for proper documentation and legibility of the notes in the record. All health care providers shall enter patient progress into the system based on their login ID.

iii. Every patient must have either a provisional or final diagnosis recorded on discharge or upon death.

iv. The diagnosis and cause of death for all patients shall follow the ICD code.

v. Referral letter and other hard copy documents which is not in EMR and related to the patient's care shall be digitised and hard copies to be kept in patient's case notes.

vi. All referred radiological images from external Hospitals should be digitised and the original copies returned to the referring Hospitals or the patient.

vii. No hard copy of medical records and documents shall be allowed to be brought out of the Patient Information Department without prior permission from authorised personnel. The medical reports or documents are not allowed to be taken out of the Hospital.

viii. All records and information of patients are confidential. The patients' medical records shall belong to the Hospital. Release of patient information to other parties, except by court order requires prior consent from the patient or relevant authority.

ix. Management of medical records shall be under the responsibility of the Patient Information Department. The records shall be managed to ensure safety, confidentiality and fast retrieval.

x. All other personnel involved in the handling of medical records shall also be responsible for maintaining the confidentiality and safety of the records.

xi. A Medical Record Committee shall coordinate all issues pertaining to medical record services.

xii. The management of patient medical records shall comply with existing guidelines[43].

xiii. Refer to circular by MOH regarding medical record disposal[44].

[43] Pekeliling Ketua Pengarah Kesihatan Bil. 17/2010: Garispanduan Pengendalian Dan Pengurusan Rekod Perubatan Pesakit bagi Hospital-Hospital dan Institusi Perubatan
[44] Pekeliling Ketua Pengarah Kesihatan Bil. 13/2016 (Pelupusan Rekod Perubatan)

xiv. The disposition of hard copies of medical records must comply with existing law and regulation[6].

B. Medical Report

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

ii. The medical report shall be prepared by a MO or Specialist in the respective discipline involved in the care. The completed medical report applications are to be processed and provided within 28 working days from the date of application.

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 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 or specialist managing the case and verified by the Head of Department or Hospital Director before release.

v. The medical report shall be charged in accordance with the Hospital fees schedule and Fees Act 1982[45].

vi. Existing guideline shall be complied in the preparation of Medical Report[46].

C. Medical Statistics

i. Statistics and reports shall be generated by the HIS system, as specified by the Hospital Management or the Medical Record Committee of the Hospital.

ii. The respective department/unit shall submit data to the Patient Information Department within the specified time.

iii. Request for medical data and statistics of the Hospital shall be done through the Patient Information Department and release is subject to the Hospital Director's approval.

D. Medical Board

i. A Medical Board may be established under eight (8) circumstances, according to guidelines from MOH[47].

ii. A Medical Board application must be made through the State Health Office or the Hospital Director's Office.

iii. Application for other circumstances than those in the guideline shall be sent in writing according to the reasons.

iv. The application for Medical Board shall be charged following the fees schedule[45].

[6] National Archives Act 2003 (Act 629) Laws of Malaysia
[45] Fees Act 1982- Fees (Medical) (Amendment) Order, 2016
[46] Pekeliling Ketua Pengarah Kesihatan Bil. 16/2010: Garispanduan Penyediaan Laporan Perubatan di Hospital-Hospital dan Institusi Perubatan
[47] Buku Garispanduan Penubuhan Lembaga Perubatan Di Jabatan Kesihatan Negeri, Institusi Perubatan & Hospital-Hospital Kementerian Kesihatan Malaysia, June 2010, m/s 2-3

4.11 Procedures and Surgery

i. Each procedure or surgery is planned and documented well in the patient's case notes. Referral to the Anaesthetic Clinic will be required before elective surgery if there is concern regarding fitness for surgery.

ii. All consent must be taken before any procedure or surgery.

iii. Upon arrival at the OT, the OT nurse must verify with the relative/patient regarding the following based on a checklist:

- Patient's details by verbal questioning and Hospital identification tag
- A consent signed by relevant parties
- Type of operation
- Site of operation (if relevant)

iv. The surgery performed shall be recorded using a prepared format and attached to the patient's case notes. Documentation should include the postoperative diagnosis, the description of the surgical procedure, the findings and any surgical specimen sent and the name of the surgical and anaesthetic team members (attending doctors and nurses). The patient's postoperative care plan shall also be documented.

v. The safety of the patient undergoing surgery shall adhere to the Safe Surgery Saves Lifes (SSSL) Initiative[48].

4.12 Drugs and Medication

4.12.1 Usage

i. HUiTM Drug Formulary shall be maintained and used as a guide for drug prescription. Any omission and exclusion of drugs shall be discussed and decided in *Jawatankuasa Pengurusan Ubat dan Stok Pakai Habis (PUSPa).*

ii. Prescription and supply of drugs not listed in the HUiTM Drug Formulary shall require approval by the PUSPa.

iii. The respective Head of Department shall be responsible for justifications of drug usage and cost implication. Request for approval shall be made using Proforma Form and submitted to PUSPa.

iv. All operational process under Pharmacy Department shall follow existing laws and regulations[31] [49].

4.12.2 Prescription

i. Authorised doctors shall prescribe drugs only to registered patients.

ii. A prescription must be done through EMR. A manual prescription will not be entertained unless there are technical issues except ED.

iii. Prescription (more than 1 month) shall be filled in at specified intervals.

[48] Safe Surgery Saves Lifes (SSSL), 2nd Edition 2018
[31] Dangerous Drugs Act 1952 [Act 234] Laws of Malaysia
[49] Poison Act 1952, Laws of Malaysia

a. Patients with new prescriptions shall collect their medicines within one week from the prescription date or before the prescription expires

b. Patients with Balance Medication Sheet (BMS) shall collect their medicines within one week from the collection date or before the prescription expires.

4.12.3 Dispensing

i. Drugs shall be dispensed at the specified pharmacy counter for one month duration and subject to availability of drugs.

ii. Drug counselling shall be provided to individual patients based on needs.

iii. All dispensing processes shall be done by trained pharmacy personnel.

iv. Urgent needs after office hours for inpatients shall be dealt by the pharmacy personnel on call.

v. Value-added services for drug collection such as Medicine Delivery, Call "N" Pick and Drive-Thru shall be established to improve the efficiency of drug dispensing.

vi. Patients who brought their medication will have this medication served to them by the staff nurse.

4.12.4 Monitoring

i. Usage of drugs, prescriptions and inappropriate drug reaction shall be monitored (medication error reporting & Adverse Drug Reaction) by the Pharmacy Department. PUSPa will coordinate, monitor and manage all issues relating to drugs and drug usage.

ii. Monitoring in terms of current stock level including slow-moving and near expiring medication shall be done regularly by the Pharmacy Department under the Main Store to ensure optimal usage of drugs.

4.13 Sterilization and Disinfection

4.13.1 Sterilization and Disinfection Services

i. The CSSU shall be overall responsible for the sterilization and disinfection services in the Hospital.

ii. Sterilization and disinfection of equipment and surgical items shall be carried out using the appropriate and accepted techniques or methods.

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

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

v. The Unit shall ensure that equipment is in good condition and develop a plan for the restoration and replacement of non-functioning equipment.

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

vii. For a high-risk patient, such as a known case of HIV/AIDS and Hepatitis B/C disposable sets shall be used when available.

viii. Sterile materials shall be distributed to all locations via designated routes in key and locked distribution trolleys.

ix. Utilization of sterile disposable items or equipment is preferred wherever permitted by the availability of the resource.

x. Sterilization of instruments from other institutions requires authorization from the Hospital Director.

xi. Loaned equipment shall be sent to CSSU 24 hours before procedure.

4.13.2 Sterile Supplies

i. The CSSU shall receive and return sterile medical instruments and sterile linen from the wards and departments on a regular basis.

ii. Used CSSU packs from the departments shall be kept in a clean transport trolley after the initial rinse and prepared for collection by the CSSU on a regular basis.

iii. Sterilization of instruments and materials shall be at the CSSU, except for:

- Flash sterilization of dropped equipment at the OT and Dental Clinic
- Sterilization of milk bottles at the milk kitchen
- Sterilization of pharmaceuticals at Pharmacy Department
- Sterilization of laboratory media, glassware and infectious specimens at the Clinical Diagnostic Laboratories.

iv. Disinfection of certain medical equipment and materials will be managed in Haemodynamics Room or Day Care Unit and shall be the responsibility of the respective department.

4.14 Infection Control

i. The Hospital Infection and Antibiotic Control Committee (HIACC) shall be established and consist of an Infectious Disease Consultant or Clinical Microbiologist, assisted by an Infection Control Doctor and an Infection Control Nurse. This committee shall be chaired by either the Clinical Microbiologist or Infectious Disease Consultant.

ii. HIACC shall coordinate all activities related to infection control. Issues pertaining to hospital infection shall be presented to the Committee for further action.

iii. An Infection Control Coordinator shall be appointed by the Hospital Director. The coordinator, together with the liaison officer (link nurse/staff) from each area/ward, shall form the Infection Control Team.

iv. The team shall monitor the implementation of infection control procedures, carry out surveillance activities, monitor antibiotic resistance pattern and conduct training of Hospital staff.

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

vi. Staff shall be instructed to adhere to barrier nursing and standard precaution guidelines at all times. This includes frequent hand washing and the use of personal protective equipment by those having direct contact with an infectious patient following hand hygiene practice.

vii. Personnel with occupational exposure to HIV/AIDS, HBV and HCV infections should follow recommendations for Post Exposure Prophylaxis (PEP) to prevent possible transmission.

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

ix. 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 contract. Refer to practise guidelines[50] [51].

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 Department/Unit headed by Health Education Officer, in collaboration with the Department of Public Health shall plan, coordinate, implement, monitor and evaluate all activities related to health/patient education programs in line with current HUiTM policies.

iii. The Department of Public Health, in collaboration with Health Education Department/ Unit, shall plan, coordinate, implement, monitor, and evaluate all activities related to health promotional activities to the staff and Hospital clients in line with current HUiTM policies.

4.16 Organ Donation

i. The Hospital Director shall establish an Organ Donation Committee to coordinate the process of organ donation and procurement.

ii. All potential cases for cadaveric donations shall be made known to the committee.

iii. Policies and procedures shall be made available to guide the procurement, donation process and transplantation of organs and tissues. They are consistent with the relevant laws and regulations and respect the community values, spiritual beliefs and religions[52] [53].

4.17 Ethics and Law

The Hospital shall abide by the laws of the country, policies and guidelines of the University, 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.

[50] SPKPK Bi1.6/1994 Garispanduan Untuk Membuang Alat- alat Suntik, Alat-alat Tajam dan Jarum Yang Telah Digunakan Di Hospital, Klinik Dan Pusat Kesihatan Di Dalam Sektor Kerajaan Dan Swasta, 13 September 1994
[51] SPKPK Bil.2/1990 Guidelines On Control of Hospital Acquired Infections, 7 February 1990
[52] National Organ, Tissue and Cell Transplantation Policy, 2007, MOH
[53] SPKPK Bil 4/2008 Pekeliling KPK BIL 4-2008 - Perkhidmatan Perolehan Organ Dan Tisu Kadaverik

Chapter 5:
Medical Facilities

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5.1 Specialist Clinics

i. Specialist Clinics shall operate from 8.00 am to 5.00 pm on working days.

ii. All specialist clinics shall provide specialist outpatient care under the supervision of the specialist in charge and shall remain operational during office hours.

iii. Whenever necessary, Consultation & Examination rooms shall be shared between the various departments/units. Throughout the consultation, the patient's privacy must be maintained based on a predetermined clinic schedule. If a patient requires private consultation, the patient shall inform the officer in advance so that a setting that respects the privacy of the patient can be arranged.

iv. Access to specialist outpatient clinics is through written/e-mail/apps referral and appointments only. The respective department shall have appropriate processes in place to manage specialist outpatient services. Appointments for external referrals shall be obtained at the Specialist Clinics Registration Counter.

v. A staggered appointment system shall be used to schedule patient appointments. Every effort shall be taken to ensure appointments take place at, or as close as possible to the scheduled appointment time. In the event the patient arrives in advance or later than 30 minutes of the scheduled appointment time, the patient may be accommodated if possible, or maybe offered another appointment at the discretion of the treating clinician.

vi. Referral letters shall be sent to the Medical Records Office for documentation.

vii. Specimens collection shall be at designated rooms and sent to the main laboratory.

viii. Patients with prescriptions shall collect their medication at the Outpatient Pharmacy.

ix. Allocation of appointments for patients accessing specialist outpatient clinic is based on prioritization, clinical urgency and available resources.

x. Rescheduling, cancellation and deferral of appointments shall follow the policy of the department/unit.

xi. All patients accessing specialist clinic services must provide the relevant documents to facilitate appointment scheduling and registration, such as referral letter, appointment card, guarantee letter etc.

xii. Payment-related services shall be charged according to the Hospital Fees and receipt issued.

xiii. All clinics shall display their client charter, which must be consistent with the daily services rendered. All clinics must ensure that the duration to obtain an appointment for all new patients is within a reasonable period. These must be monitored regularly by the clinic for continuous improvement.

xiv. Details of the clinic consultation shall be documented in the EMR. At the end of the clinic session, the patient may be either discharged, given another clinic appointment, referred elsewhere or admitted to Day Care/Wards for investigations/procedures/ treatment.

5.2 Emergency Department

The Hospital shall provide pre-Hospital and Hospital emergency services on a 24-hour basis. The Department shall be responsible for the provision of emergency care to patients to save lives, preserve body functions and prevent complications. The services shall be under the responsibility of the Head of ED.

i. The department shall have designated areas or zones for the management of patients according to the severity of illness.

ii. All patients shall be triaged according to the Malaysian Triage Category (MTC); resuscitation for the critically ill, intermediate zone for the semi-critical and non-critical zone. Critically ill patients shall be seen immediately by the attending doctor.

iii. Waiting time for the non-critical zones shall be displayed at the ED. Locum services may be provided upon approval by the Hospital Director.

iv. An observational medicine area shall be provided for the observation of a selected group of patients presenting to the ED and subjected to a predefined care plan. The period of observation shall not exceed 6 hours unless clinically appropriate. The preadmission management plan shall be carried out by the primary team.

v. During a disaster, the Department shall play a lead role in the initial management and treatment of the victims on-site and inside the Hospital.

vi. Standby medical cover shall be coordinated by the Department and provided on request subject to the availability of staff and the policy and procedures of HUiTM.

5.3 Daycare

The Daycare unit shall be utilized by relevant clinical disciplines for medical treatment, endoscopy and elective surgeries. A record of the procedures performed as Daycare will be maintained.

i. Daycare services shall run from Monday to Friday (working days) from 7.00 am to 9.00 pm.

ii. All patients scheduled for Daycare services shall be given written information regarding registration and admission. Consent for surgery or other special procedures shall be obtained in a separate consent form by the doctor who scheduled the case for a daycare procedure.

iii. Confirmation of patients undergoing daycare procedures must be made at least 24 hours before the procedure by the daycare staff.

iv. Patients undergoing daycare procedures must be pre-selected, assessed and categorized as low-risk patients. These patients shall be registered and discharged within the same day after the surgery/procedures.

v. Patients shall be certified fit by a MO before discharge; if they are deemed unfit, they shall be admitted for further in-patient management.

vi. On registration at the Daycare, fees shall be collected before the procedure is performed. If there shall be any change in the procedure, the difference in the charges shall be reimbursed to or paid by the patient.

vii. Billing for these patients shall be in accordance with the Hospital Fees.

5.4 Operation Theatre

i. The Hospital management shall be responsible for providing OT facilities to cater for elective and emergency procedures involving general, regional and local anaesthesia.

ii. All elective surgeries shall be carried out between 7.00 am to 4.00 pm (or longer if necessary) on normal working days according to the schedule by the respective department based on the allocated OT days.

iii. Emergency OT shall be operational 24 hours a day. Whenever needed, additional Emergency OT shall be opened.

iv. The Anaesthetic MO or Specialist shall assess all patients undergoing elective and emergency surgery.

v. All procedures carried out in the OT shall comply with all existing guidelines and policies including the SSSL initiative.

5.5 Intensive Care

5.5.1 Admission

i. Admission to Intensive Care (Adult ICU, Cardiac ICU, CCU, Paediatric ICU, Neonatal ICU) and HDU is based on the request of the primary team or the attending doctor. The decision to admit is based on the specialist in charge of the unit if the patient meets the requirement for intensive care.

ii. Priority for admission shall be based on the urgency of the patient's need for intensive care. Unscheduled, emergency admission shall take precedence over scheduled elective surgical admission. Triaging of admissions to the unit shall be done by the Specialist in charge of the unit.

5.5.2 Discharge from Intensive Care

i. The decision to discharge from the unit to another ward/facility is based on the Specialist in charge of the unit when the reason for admission has resolved. A Discharge Summary must be completed and attached in the patient's case notes.

ii. When continuing intensive care for a patient is deemed medically futile, end-of-life care shall be considered. This decision shall be discussed with the patient's family and with other team members as appropriate. Referrals to Organs Procurement Team shall be initiated whenever possible.

iii. The Specialist of the primary department/unit shall discuss with the Specialist of the intensive care team when relatives/next-of-kin request termination of treatment and DAMA for ill ventilated patients. Adequate explanation and the risks shall be made known prior to approval for discharge.

iv. DAMA patients shall not be accompanied home by a nurse. Extubation of the patient and removal of oxygen supply or drip shall be carried out in Intensive Care.

v. In cases where relatives/next-of-kin requesting for ill ventilated patients to be transferred to other medical facilities, the Specialist shall discuss and provide adequate explanation including the risks involved prior to approval. Pre-transfer communication between the Specialists of the referring and receiving unit/facility shall be documented.

vi. For a referral to a private facility on patient's request, the arrangement for the transport and care during the transfer shall be the responsibility of relative/next-of-kin and may be facilitated by the Intensive Care personnel.

5.5.3 Management

i. Patients admitted to Intensive Care shall be cared for by the primary team and the Specialist in charge of the Intensive Care.

ii. The clinical management of patients in the Intensive Care unit shall be guided by management protocols in Intensive Care and other relevant guidelines/ protocol.

iii. All categories of staff shall be credentialed and privileged to perform specific tasks appropriate to their level of skills and competency.

iv. Communication with the patient and family members is essential and there shall be full disclosure of any unexpected adverse outcome by the attending Specialist.

v. Communication among the Healthcare Providers shall be enhanced. Intra and inter-departmental communication shall be open, honest and effective to ensure optimal patient care. Staff shall display respect and tolerance towards others to maintain a harmonious interpersonal relationship.

5.6 Forensic Services

i. Forensic and mortuary services shall be provided by the Hospital. The service shall be under the responsibility of a Forensic Pathologist appointed as the Head of Department by the Hospital Director. He/she will be involved in the planning, management, and provision of quality and safe forensic services.

ii. The services will include but not limited to the provision of body reception, body storage, body preparation area, area for viewing and bereavement and autopsy suites.

iii. Appropriate transport to transfer the body to the mortuary shall be provided in a dignified manner.

iv. Complete records shall be maintained and include the following:

- Registration of bodies received.
- Registration of medico-legal and non medico-legal cases.
- Records of body released to the next-of-kin including transport to the final destination.
- Release and disposal records of unclaimed bodies.
- Records of medico-legal and clinical post mortem cases.
- Records of post mortem report requests and court proceedings.

v. Where a post mortem is required, the policies and procedures related to the medico-legal or clinical type of post mortem examination must be clear, accessible and understood by the forensic staff. In medico-legal post mortem, the chain of custody of the deceased person, trace evidence and specimens obtained during the procedure shall be maintained at all times, as required by the law.

5.7 Clinical Diagnostic Laboratory Services

i. Laboratory services are performed in Clinical Diagnostic Laboratories. The services shall be organised and administered to provide high-quality diagnostic service for safe patient care.

ii. Department of Clinical Diagnostic Laboratories shall provide a current Clinical Diagnostic Laboratories Handbook and documented quality procedures for staff reference as a guide for specimen collection, handling and transportation to the laboratory.

iii. Tests shall only be requested by authorised personnel involved in patient management. The request is made using the Computerized Order Entry in the integrated HIS/ Laboratory Information System (LIS). Requests for transfusion medicine services are made using hard copy forms.

iv. Specimen collection shall follow the guidelines provided by the Department of Clinical Diagnostic Laboratories. Whenever possible, automated sample delivery e.g. via pneumatic tube shall be made available. The department is responsible for monitoring the transportation of the samples to the laboratory to ensure the quality of test results is maintained.

v. The system shall enable the validation of all relevant tests by identified competent persons.

vi. Important steps in specimen movement/process shall be recorded in the HIS/LIS. The automatic flow of information to/from analyser machines is feasible in an integrated HIS.

vii. All results shall be viewed electronically via the EMR. The reports of the investigation requested by other hospitals shall be made by the requesting physicians and sent via a mutually agreed and safe format.

viii. Standardization of practices and procedures shall be implemented in all the laboratories where possible.

ix. Clinical interpretation of test result/report is made by clinically qualified personnel (Pathologist/Clinical Microbiologist). The laboratory shall notify the ward/clinic of abnormal test results exceeding “critical values” that are established at the national level. There shall be a documented procedure for handling and reporting urgent requests.

x. The outsourcing of services shall be arranged with accredited or technically competent referral laboratories through the Department of Clinical Diagnostic Laboratories. The department shall maintain a list of referral laboratories.

xi. Point of Care Testing (POCT) equipment are under the responsibility of the users and department and shall follow the National guideline[54].

xii. Laboratory safety practices shall comply with the existing laboratory safety requirements and all relevant statutory acts and regulations. All Clinical Diagnostic Laboratories personnel shall be given adequate training in laboratory safety.

xiii. Clinical Diagnostic Laboratories shall be accredited by a renowned accreditation body to ensure delivery of services of the highest standard.

5.8 Radiology Services

i. All radiology procedures shall be performed by qualified and credentialed personnel. Notwithstanding the above, medical personnel who have undergone appropriate training in specific procedures may be privileged to perform the procedures.

ii. A radiological investigation or procedure shall be performed upon request from a registered medical/dental practitioner and when deemed appropriate by a Radiologist. Such a request shall contain clinical information to justify the examination.

iii. All requests for radiology examinations shall be accompanied by duly completed radiology request forms/order entries (including consent and checklist, if relevant).

iv. The Department shall be fully operational for all types of examination during office hours.

v. Outside office hours, radiological examinations shall be performed according to urgency.

vi. Examinations on a patient shall be carried out in the presence of an appropriate chaperone.

vii. For all radiological examinations involving ionizing radiation, the dose/exposure factors/fluoroscopy time shall be recorded.

[54] National Point of Care Testing Policy and Guidelines, 2012, MOH

Chapter 6:
Hospital Amenities

Izzat Ismail, Mohd Khairil Izwan Md Daim.

6.1 Staff Facilities

i. Staff facilities shall either be allocated to individuals or commonly shared by all staff.

ii. Doctors on-call shall be provided with on-call rooms.

iii. Staff accommodation or quarters shall be provided to staff based on service needs, availability and eligibility.

iv. Staff clinic shall be established to provide primary medical care for Hospital staff.

6.2 Public Facilities

i. Public facilities shall be under the responsibility of Hospital Management. Facilities available for public use include:

- Visitors' Lounge *(Balai pelawat)*
- Prayer rooms (Surau)
- Breastfeeding room / baby changing room
- Cafeteria
- Toilets including for the disabled
- Shops/Vending Machines
- Auto-teller machines (ATM)
- Police base
- Parking

ii. Visitors' Lounge *(Balai Pelawat)* and other designated waiting areas for the patient's relatives shall be opened over 24 hours. Those who use the lounge shall be subjected to the rules and regulation of the Hospital.

iii. Prayer rooms shall be opened over 24 hours to the public and staff.

iv. A common cafeteria located at the Hospital building is available for staff and the public. The cafeteria shall be operated by foodservice contractors appointed by the Hospital.

v. Shops are available at the main Hospital building.

vi. Food delivery services are only allowed in designated areas.

6.3 Car Park

i. All Hospital staff shall park their vehicles at the designated staff parking areas.

ii. Only cars with UiTM staff sticker shall be allowed to enter the staff parking area. All staff vehicles must display the UiTM staff sticker.

iii. Visitors shall park in any available, non-assigned parking space for visitors.

iv. Ambulances and other Hospital vehicles shall be parked at designated areas.

v. Designated disable person parking areas shall only be used by a disabled person identified by an OKU sticker or card. Unauthorised vehicle parking in this area shall be clamped by security personnel.

vi. No parking shall be allowed at the entrance of ED.

vii. Designated police, fire & rescue vehicles parking shall be made available within the vicinity of ED.

viii. The Hospital or UiTM shall not be responsible for the safety of the vehicles. Signages shall be displayed to the public that vehicles are parked at their own risk.

ix. Access to the Hospital complex from car parks shall be through the main entrance, drop-off entrances and staff designated entrances.

x. The traffic shall be directed to the respective entrances of the Hospital namely ED, Specialist Clinics, Dialysis Unit, Main Lobby, Labour Delivery Suite, Rehabilitation Medicine, Psychiatry Department and Oncology.

xi. Management of car parks shall be carried out by the Infrastructure Department and may appoint an outsourced company to run the car park services.

Chapter 7:
Quality Management

Julina Md Noor, Mohd Amin Mohd Mokhtar, Suraya Abd Razak, Fatim Zulaika Mohamed Ali, Mahfuzah Ruselan.

7.1 Standards

i. The Hospital performance in quality care shall adhere to MSQH Hospital Accreditation Standards and Key Performance Indicators (KPI).

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

iii. The Hospital shall establish its specific indicators for monitoring quality within the Hospital, department/unit.

7.2 Quality Improvement Activities

i. The Hospital shall establish the Quality Improvement and Patient Safety Department that oversees the quality initiatives of the Hospital. This department shall be led by a Clinical Specialist appointed by the Hospital Director. Coordinators shall be appointed for the different activities.

ii. The following quality activities shall be implemented:

- Quality Assurance studies
- Quality Control Circle
- Malaysian Patient Safety Goals
- Incident reporting
- Hospital Accreditation certification
- Clinical Audits
- Ekosistem Kondusif Sektor Awam (EKSA)
- Mortality Reviews (suspicious deaths, peri-operative and postoperative deaths, maternal mortality, perinatal and neonatal mortality, specific communicable diseases death such as dengue, tuberculosis, leptospirosis and others in accordance to Notifiable Disease Act[55].
- Root Cause Analysis (RCA)
- Pain-free Hospital
- Safe Surgery Saves Lives (SSSL)

iii. Every Clinical and Non-Clinical Department is responsible for its Quality Programme to ensure continuous improvement to the delivery of health care services.

7.3 Training

7.3.1 Continuous Professional Development Programmes

i. The Hospital management shall facilitate Continuous Professional Development (CPD) activities in the Hospital.

ii. The Hospital shall establish a Training Unit and Training Committee to provide the direction and governance for the CPD programme.

[55] Prevention and Control Of Infectious Disease Act 1988, MOH

iii. Each personnel (both administrative and clinical) will be allowed to attend training programmes in areas relevant to their functions, of not less than 7 days to maintain staff competency, which include technical, soft skills and communication skills. Where applicable, logbook or online CPD activities should be updated.

iv. Staff shall be responsible for his/her professional development to improve work performance. The Head of Department/Unit shall suggest appropriate training for individual staff to develop his/her knowledge and skill.

v. Sufficient funding and other resources which may include library, auditorium, seminar room, skills lab, computer lab etc. will be established in the Hospital.

vi. The Hospital shall establish formal and informal linkages and collaborations with local and international health-related organisations to facilitate training activities.

vii. Databases of in-house and external training programmes organised and/or attended by each person must be maintained and updated by the Training Unit.

7.3.2 Credentialing & Privileging

i. The Hospital shall establish committees consisting of clinicians and senior allied health staff to coordinate credentialing & privileging (C&P) processes:

- Medical and Dental Advisory Committee (MDAC)
- HUiTM C&P Committee
- HUiTM C&P Technical Committee for Medical Practitioner
- HUiTM C&P Technical Committee for Clinical Support Staff

ii. The C&P committee shall also identify procedures requiring additional training and experience in particular;

- Invasive procedures requiring skill and knowledge
- High-risk procedures
- New technologies/techniques
- Complex procedures
- Procedures where the appropriateness of indications for use are open to abuse.

iii. Each speciality shall be responsible for determining the “core clinical activities” within the speciality.

iv. Each speciality shall be responsible for the identification of training requirements for its subspecialty, the organisation of training courses and workshops.

v. The C&P Committee shall determine and delineate the clinical privileges of a healthcare provider within the said department, consistent with his or her credentials, clinical competency and the Hospital’s needs, capability and resources.

vi. The C&P committee shall periodically review the privileges granted after a defined period.

vii. The Head of Department is responsible for verifying and assessing professional performance, peer recommendation, clinical judgments and/or technical skills.

viii. A practitioner whose credentialed status is denied, withdrawn or limited has the right to appeal to the Medical & Dental Advisory Committee (MDAC) of the Hospital. The Hospital Director's decision, following consultation with members of the MDAC, will be final and binding.

ix. All visiting clinicians shall apply for credentialing and privileging from the HUiTM C&P Committee. Refer to existing practise guidelines[56] [57].

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

i. As the Hospital also serves as the training centre for undergraduates/ House Officers and/or other post-basic/graduate programmes, the Hospital is required to establish a formalised training and assessment structure relevant to the type of training being provided.

ii. Compliance with the Medical Staff Bylaws shall also be observed.

7.4 Research

i. The Hospital shall promote, support and facilitate the conduct of clinical and non-clinical research.

ii. All research-related activities at the Hospital shall be registered and under the supervision of the Head of Research, Linkages and Innovation.

iii. All research must be registered at the Research, Linkages and Innovation Office before the commencement of the study and the office shall facilitate the conduct of research.

iv. All clinical research conducted at the Hospital must be registered with the Research Management Centre (RMC) (https://rmc.uitm.edu.my/v2/) and approved by UiTM Ethics Committee. Also, the study must be sanctioned by the Hospital Director and the respective Head of Department.

v. All non-clinical research conducted at the Hospital must be registered with RMC and the study must be approved by the Hospital Director.

vi. The Principal Investigator (PI) shall be responsible for obtaining approval from UiTM Ethics Committee for the conduct of any research involving humans, sensitive issues e.g. culture, race, religion or research related to any UiTM policy matters.

vii. All PI, Co-investigator and Research Collaborators, who undertake interventional clinical trials must possess a Malaysian Good Clinical Practice certificate (MGCP).

viii. All Interventional clinical trials must include a PI or Co-investigator from the Hospital.

[56] SPKPK Bil.11/2008 Panduan Penggunaan Khidmat Doktor Swasta Untuk Perkhidmatan di Klinik Kementerian Kesihatan (Hospital dan Klinik Kesihatan) dengan Kadar Baru RM80 sejam, 24 August 2008
[57] SPKPK Bil.4/2001 Garis Panduan Pengambilan Pakar Swasta untuk Berkhidmat di Hospital-Hospital Kerajaan, 22 February 2001

ix. All Clinical Trial Agreement (CTA), Research Agreement and Non-Disclosure Agreement between sponsor or collaborator and the Hospital PI shall be reviewed by office of Research, Linkages and Innovation prior to the approval by the Hospital Director.

x. Any presentation (oral/poster) or publication, e.g. research reports, abstracts, manuscripts, or conference proceedings by the Hospital staff must be registered with the office of Research, Linkages and Innovation.

xi. The Hospital shall maintain the medical records of patients involved in clinical trials.

xii. All other relevant research documents shall be maintained by units under the purview of the Department of Research, Linkages and Innovation for audit and monitoring. Management of such records by the PI and the sponsor shall be governed by good clinical practice.

Chapter 8:
Disaster Management

Izzat Ismail, Julina Md Noor, Mohd Amin Mohd Mokhtar, Fatim Zulaika Mohamed Ali, Mahfuzah Ruselan.

8.1 Disaster & Emergency Preparedness

i. There shall be a Disaster & Emergency Preparedness Committee headed by the Hospital Director.

ii. The members of the committee shall include Deputy Director (Clinical Support), clinicians from various relevant departments and administrators.

iii. The Committee shall develop a Hospital Disaster Management Plan which includes *Emergency Incident & Internal Disaster Action Plans and Disaster Management Plan* for external incidents such as fire, flood, earthquake, bomb threats, chemical threats, biological threats, disease outbreak, mass casualty and others.

iv. The Committee shall be involved in all the phases of Disaster Management (Prevention, Preparedness, Response and Recovery).

8.2 Phases of Disaster Management

8.2.1 Prevention Phase

i. The Disaster & Emergency Preparedness Committee shall be responsible for the activities involved in the prevention phase of disaster management.

ii. The plan shall include the following:

- Risk identification of potential internal and external hazard of the Hospital;
- Risk communication to the various stakeholders within the Hospital, State Health Office and Ministry of Health, Universiti Teknologi MARA, Ministry of Higher Education; and
- Response capacity assessment.

iii. The Disaster & Emergency Preparedness Committee shall propose structural and non-structural preventive measures that can be implemented by the Hospital to minimise the hazard threat.

8.2.2 Preparedness Phase

The Hospital shall have a comprehensive plan which includes a contingency plan and SOP in handling any emergency or disaster. Reference may be made to available directive and guidelines[58][59][60].

i. The Hospital Disaster Management Plan shall be developed during this phase.

ii. The Committee shall meet on a regular basis and shall be responsible for the development and implementation of the hospital contingency plan and SOP pertaining to the disaster preparedness.

iii. The Hospital Disaster Management Plan shall be communicated to all staff.

iv. All departments shall have their SOP and evacuation plan in the event of any emergency or disaster. An exit route plan is to be displayed at strategic locations in every Department/Unit/Ward including the assembly areas.

v. Staff shall be trained on the use of equipment, patient transportation and evacuation processes etc.

[58] Pelan Pengurusan Bencana Peringkat Kementerian Kesihatan Malaysia (Refer to Sektor Pengurusan Wabak & Bencana KKM, Mac 2015)
[59] Pelan Tindakan Insiden Kecemasan dan Bencana Dalaman Bagi Hospital-Hospital KKM (Refer to Medical Development Division, Ministry of Health 2018)
[60] Arahan 20, Majlis Keselamatan Negara (Dasar dan Makanisme Pengurusan Bencana Negara)

i. Hospital mock disaster drills and tabletop exercises shall be carried out annually and evaluated accordingly.

ii. Business Continuity Plan (BCP) shall be included in the Hospital Disaster Management Plan.

8.2.3 Response Phase

i. In the event of a disaster, the disaster declaration of the Hospital shall be made by the Hospital Director and activated according to the Hospital Disaster Management Plan.

ii. The Hospital Disaster Management Plan shall be carried out in a systematic and planned manner.

iii. Disaster Operation Room shall be created in the ED and an administrative area in the event of a disaster.

iv. For an internal disaster such as fire, earthquake, bomb threat etc, the hospital evacuation plan shall be carried out.

v. The BCP shall be implemented during this phase.

8.2.4 Recovery & Assessment Phase

i. When the disaster has passed, the Hospital Director shall declare the stand-down order, according to the Hospital Disaster Management Plan.

ii. The Recovery & Assessment Phase shall be carried out according to the SOP lined out in the Hospital Disaster Management Plan.

iii. The Committee shall prepare a post-mortem report of the incident or disaster.

iv. The Committee shall identify and assist in the treatment of Post-Traumatic Stress Disorder (PTSD) among the staff.

8.3 Specific Contingency Plan

i. A specific contingency plan shall be available for the following situations,

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

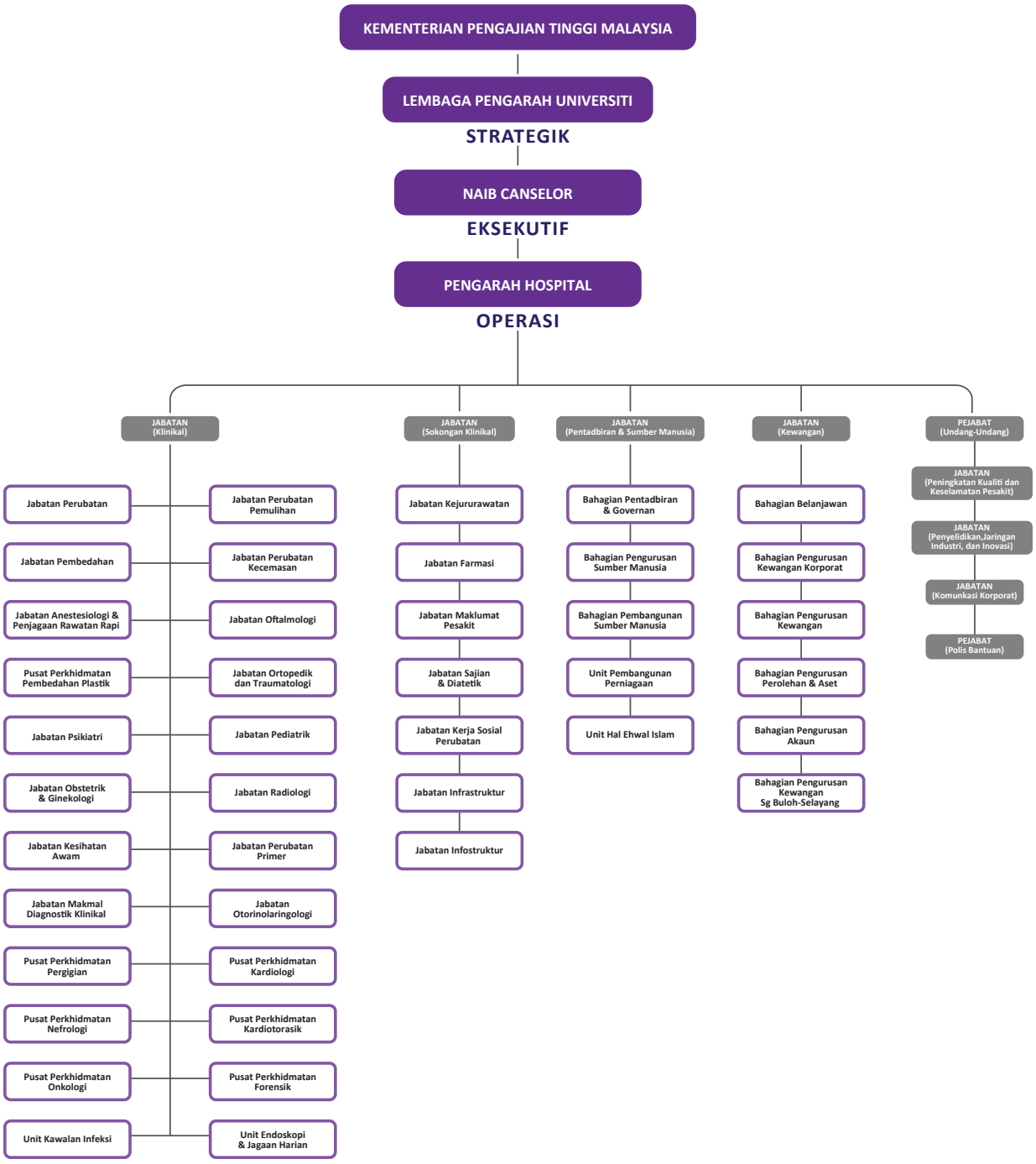
ii. The plan includes notifications, allocation of responsibilities, immediate actions, alternative solutions and follow up measures.

iii. Staff will be briefed on the plan and appropriate training shall be carried out.

3

APPENDICES

CARTA ORGANISASI
HOSPITAL UNIVERSITI TEKNOLOGI MARA



Appendix 1

TADBIR URUS HOSPITAL UiTM

LEMBAGA PENGARAH UNIVERSITI (LPU)

TIER 1-STRATEGIK

Menggubal dasar, matlamat dan memantau prestasi dan terlibat dengan membuat keputusan penting.

MAJLIS PENGURUSAN HOSPITAL

TIER 2-EKSEKUTIF

Bertanggung dalam pemantauan, pelaksanaan keputusan LPU, Senat dan MEU.

JAWATANKUASA PENGURUSAN HOSPITAL

TIER 3-PENGOPERASIAN

Bertanggung jawab untuk melaksanakan dasar dan hal-ehwal operasi peringkat HUiTM

PENTADBIRAN & SUMBER MANUSIA

i. Jawatankuasa Panel Pembangunan Sumber Manusia.
ii. Jawatankuasa Pembayaran Penuh Pesakit (FPP).
iii. Jawatankuasa Ruang Niaga.
iv. Jawatankuasa Latihan.
v. Jawatankuasa Imej Dan Identiti Korporat.
vi. Jawatankuasa Sumbangan.
vii. Jawatankuasa Lembaga Temuduga Jawatan Pengurusan & Profesional / Pelaksana (SKIM U).
viii. Jawatankuasa Pelawat.
xi. Jawatankuasa Kesiapsiagaan Bencana Dan Kecemasan.
xii. Jawatankuasa Keselamatan & Kesihatan Pekerja.

PENGURUSAN KEWANGAN

i. Jawatankuasa Sebut Harga Rasmi HUiTM.
ii. Jawatankuasa Tabung Amanah Hospital.
iii. Jawatankuasa Pengurusan Kewangan Dan Akaun Hospital.
iv. Jawatankuasa Pembukaan Peti Tender/Sebut Harga Rasmi UiTM Hospital.
v. Jawatankuasa Penilaian Teknikal Hospital.
vi. Jawatankuasa Rundingan Harga UiTM Hospital.
vii. Jawatankuasa Pelupusan Aset Alih Hospital.
viii. Jawatankuasa Pengurusan Pelupusan Aset Alih Kerajaan UiTM.
ix. Jawatankuasa Pemeriksaan Bajet.

PENGURUSAN KLINIKAL

i. Jawatankuasa Penasihat Perubatan & Pergigian (MDAC).
ii. Jawatankuasa Rekod Perubatan.
iii. Jawatankuasa Penggunaan Ubat & Stok Habis Pakai (PUSHPa).
iv. Jawatankuasa Ubat.
v. Jawatankuasa Transfusi.
vi. Jawatankuasa Kawalan Infeksi Dan Antibiotik.
vii. Jawatankuasa Credentialing dan Privileging.
viii. Jawatankuasa Tabung Kebajikan Pesakit.
ix. Jawatankuasa Dewan Bedah.
x. Jawatankuasa Resusitasi.
xi. Jawatankuasa Mortaliti Dan Morbiditi.
xii. Jawatankuasa Perkhidmatan Rawatan Harian.
xiii. Jawatankuasa Pengurusan Katil.
xiv. Jawatankuasa Radiasi.
xv. Jawatankuasa Klinikal Audit.
xvi. Jawatankuasa Pemandu Akreditasi MSQH.
xvii. Jawatankuasa Pengurusan Risiko.
xviii. Jawatankuasa Transplan.

PENGURUSAN SOKONGAN KLINIKAL

i. Jawatankuasa Pengesahan Bayaran dan Tuntutan Hospital.
ii. Jawatankuasa Penilaian Projek Dan Teknikal ICT & Elektronik Hospital (JITEH).
iii. Jawatankuasa Sistem Maklumat Hospital.
iv. Jawatankuasa Lembaga Perubatan.
v. Jawatankuasa Dietetik dan Sajian.

Appendix 2


ANJUNG PLATINUM

4

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59. Pelan Tindakan Insiden Kecemasan dan Bencana Dalaman Bagi Hospital-Hospital KKM (Refer to Medical Development Division, Ministry of Health 2018)

60. Arahan 20, Majlis Keselamatan Negara (Dasar dan Makanisme Pengurusan Bencana Negara)

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LIST OF ABBREVIATIONS

ABBREVIATIONS	DEFINITION
AMO	Assistant Medical Officer
AIDS	Acquired Immunodeficiency Syndrome
ATM	Auto-teller Machines
BBA	Birth Before Arrival
BCP	Business Continuity Plan
BID	Brought-in-dead
BMS	Balance Medication Sheet
BYOD	Bring Your Own Device
C&P	Credentialing & Privileging
CA	Concessionaire Agreement
CCU	Cardiac Care Unit
CenTRE	Centre For Translational Research And Epidemiology
CICU	Cardiac Intensive Care Unit
CME	Continuous Medical Education
CPD	Continuous Professional Development
CTA	Clinical Trial Agreement
CRW	Cardiac Rehabilitation Ward
CSI	Crime Scene Investigation
CSSU	Central Sterile Service Unit
DAMA	Discharge Against Medical Advice
DDA	Dangerous Drug Act
DIL	Death In Line
DNR	Do Not Resuscitate
ED	Emergency Department
EKSA	*Ekosistem Kondusif Sektor Awam*
EMR	Electronic Medical Record
GCP	Good Clinical Practise
GL	Letter Guarantee
GP	General Practitioner
HACCP	Hazard Analysis And Critical Control Point
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HDU	High Dependency Unit

ABBREVIATIONS	DEFINITION
HIACC	Hospital Infection and Antibiotic Control Committee
HIS	Hospital Information System
HIV	Human Immunodeficiency Virus
HO	House Officer
HOD	Head of Department
HOU	Head of Unit
HSIP	Hospital Specific Implementation Plan
HUiTM	Hospital Universiti Teknologi MARA
ICD	International Classification of Disease
ICT	Information & Communication Technology
ICU	Intensive Care Unit
IT	Information Technology
JKKP	Jawatankuasa Keselamatan dan Kesihatan Pekerja
JKPA	Jawatankuasa Pengurusan Kewangan dan Akaun
JPH	Jawatankuasa Pengurusan Hospital
KK	Klinik Kesihatan
KKM	Kementerian Kesihatan Malaysia
KPI	Key Performance Indicators
LIS	Laboratory Information System
LPU	Lembaga Pengarah Universiti
MAMPU	Malaysian Administrative Modernisation and Management Planning Unit
MC	Medical Certificate
MAP	Master Agreed Procedures
MDAC	Medical and Dental Advisory Committee
MGCP	Malaysian Good Clinical Practice certificate
MMC	Malaysian Medical Council
MO	Medical Officer
MOA	Memorandum of Association
MOH	Ministry of Health
MOU	Memorandum of Understanding
MEU	Majlis Eksekutif Universiti
MPH	Majlis Pengurusan Hospital
MRN	Medical Record Number

ABBREVIATIONS	DEFINITION
MSQH	Malaysian Society for Quality in Health
MSW	Medical Social Work
MTC	Malaysian Triage Category
NDA	Non-Disclosure Agreement
NICU	Neonatal Intensive Care Unit
O&G	Obstetrics and Gynaecology
OKU	Orang Kelainan Upaya
OSHA	Occupational Safety and Health Act
OT	Operation Theatre
PA	Public Address
PABX	Private Automatic Branch Exchange
PAC	Patient Assessment Centre
PACS	Picture Archiving Communication System
PEP	Post Exposure Prophylaxis
PI	Principal Investigator
PICU	Paediatric Intensive Care Unit
POCT	Point of Care Testing
POG	Project Operation Guideline
PPM	Planned Preventive Maintenance
PPUiTM	Pusat Perubatan Pakar Universiti Teknologi MARA
PTSD	Post Traumatic Stress Disorder
PUSPa	Jawatankuasa Pengurusan Ubat dan Stok Pakai Habis
QIPS	Quality Improvement and Patient Safety
RCA	Root Cause Analysis
RIS	Radiology Information System
RMC	Pusat Pengurusan Penyelidikan
RPO	Radiation Protection Officer
SIQ	Shortfall in quality
SMS	Short Message Service
SOP	Standard Operating Procedure
SSSL	Safe Surgery Safe Lives
TRPI	Technical Requirement And Performance Indicator
UACP	User Access Control Policy
UiTM	Universiti Teknologi MARA
VIP	Very Important Person

Hospital Universiti Teknologi MARA General Hospital Operational Policy is comprehensive and authoritative: it presents the essential information and uniformity required for best level of care in the hospital. It also serves as a guide for doctors, allied health professionals and hospital administrators in understanding their roles and responsibilites within the organisation. This policy book will prove invaluable to all hospital staff in ensuring standardised practices in day-to day running of the hospital, paving the way for quality measurement and improvement of healthcare deliverance.

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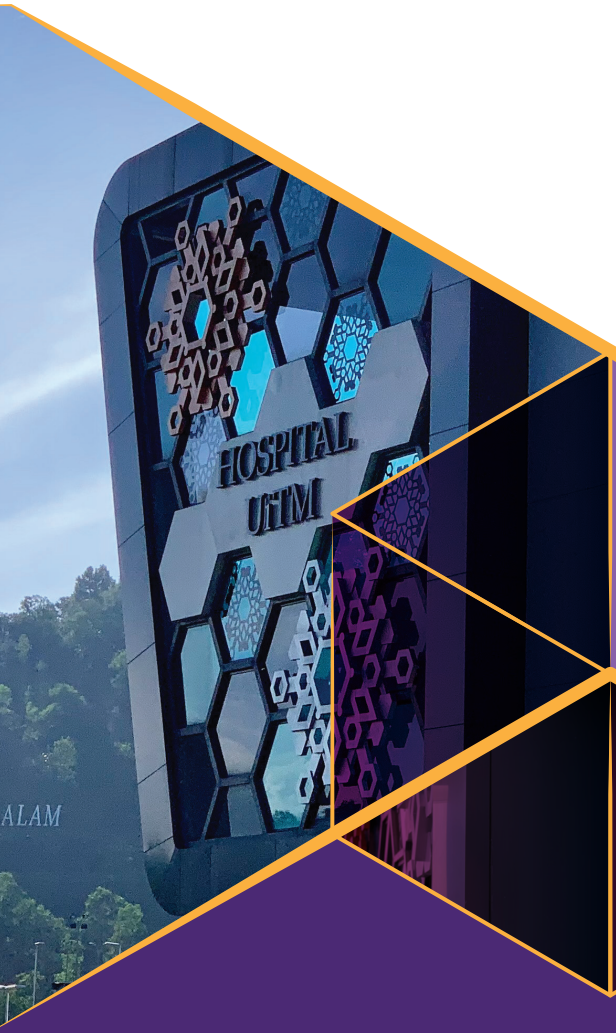

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