KEMENTERIAN KESIHATAN MALAYSIA

HOSPITAL SULTAN HAJI AHMAD SHAH

HOSPITAL SULTAN HAJI AHMAD SHAH

GENERAL HOSPITAL OPERATIONAL POLICY

2025-2027

VERSION 2

MINISTRY OF HEALTH

HOSPITAL SULTAN HAJI AHMAD SHAH, TEMERLOH

Prepared by:	Date:
Dr Mohd Zuraimi bin Mohammed Zohdi Medical Officer UD54 Head of Unit Quality Hospital Sultan Haji Ahmad Shah	14 MARCH 2025
Reviewed by:	**Date:**
En. Hazlan bin Sulaiman Hospital Deputy Director (Administration) Hospital Sultan Haji Ahmad Shah	14 MARCH 2025
Endorsed by:	**Date:**
Dr Hajjah Nor Azlina binti Abdul Aziz Hospital Director Hospital Sultan Haji Ahmad Shah	14 MARCH 2025
Next Review Date:	20 JANUARY 2027

CIRCULATION LIST

COPY NUMBER	COPY HOLDER
1	Hospital Director Hospital Sultan Haji Ahmad Shah, Temerloh
2	Quality Unit

LIST OF AMENDMENTS

AMENDMENTS		PAGE/ SECTION/ PARAGRAPH	DETAILS OF AMENDMENT	VERIFIED BY	ENDORSED BY
NO	DATE				
1.	**22/11/2024**	**4.1.2 - rephrase point no 4**	The "Pekeliling Perbendaharaan bil.5 Tahun 2007: Tatacara Pengurusan Aset Alih Kerajaan" shall be adhered to. The hospital Asset Management Unit / Committee shall be responsible for the flowing functions i.e. receiving, registering, usage, safekeeping, inspection, maintenance and disposal **(REMOVED)** The "Pekeliling Perbendaharaan – AM1.1 Pengurusan Aset Kerajaan, AM2.1 – 2.9 Tatacara Pengurusan Aset Alih Kerajaan, AM 6 Tatacara Pengurusan Stor Kerajaan and AM 7 Tatacara Pengurusan Aset Tak Ketara Kerajaan" **(NEW POLICY)**	En. Rashidi bin Muhamad, Head of Asset Management Unit.	Dr. Nor Azlina binti Abdul Aziz, Hospital Director.
2.	**22/11/2024**	**4.3.2 - no iii new policy**	iii. The Malaysian Digital Economy Blueprint 2021 has stipulated that all agencies at the federal and state levels must use cashless payments as a more effective transaction method by the year 2022. In addition, the KKM Anti-	En. Muhammad Aidid Bazli bin Bakri, Head of Finance, Accounting and Revenue Unit.	Dr. Nor Azlina binti Abdul Aziz, Hospital Director.

			Corruption Plan 2021-2022 has also outlined a cashless payment initiative cash at the health facility of the Ministry of Health to avoid leakage of Government revenue. Therefore, KKM including this hospital has implemented cashless payments from 1 October 2022. However, cash payments are still accepted if customers do not have an ATM/debit card or credit card or e-wallet. **(NEW POLICY)**		
3.	**22/11/2024**	**4.4.2.1 - no ii add sentence**	ii prepare Sasaran Kerja Utama (SKU) and MyPerformance. **(NEW SENTENCE)**	Pn. Aswati binti Gandon, Head of Human Resources, Competency & Training Unit.	Dr. Nor Azlina binti Abdul Aziz, Hospital Director.
4.	**22/11/2024**	**5.3 -no v new policy**	v. The Specialist Clinic Registration Counter also creates a R-Lane for the Senior Citizen, Children, Expectant Mothers, Disabled Persons (Orang Kelainan Upaya – OKU), Psychiatric Patients, Bedridden Patients, Special Children and others. **(NEW POLICY)**	Dr. Haizul Ikhwan bin Murat, Head Of Ophthalmology Department, Chairman of Specialist Clinic Committee.	Dr. Nor Azlina binti Abdul Aziz, Hospital Director.

5.	**22/11/2024**	**5.2** **- point no ii, iv and v (removed)** - **point no iii (new policy)**	ii. Consent shall be obtained from the patient or next-of-kin prior to carrying out any clinical procedures. In live-saving situation where all efforts to trace relatives and next-of-kin have failed, consent can be given by (2) two specialist from the related specialty for the procedure to be carried out. All efforts made to trace the relatives/next-of-kin shall be documented in the case notes iv. Consent shall be obtained from the patient if he / she is at least 18 years old and of sound mind v. For patients below the age of 18 or patient of unsound mind consent shall be obtained from the legal guardian **(REMOVED)** iii. Consent should be taken prior to carrying out any clinical procedures or treatments. In instances where consent is required it must first be obtained from: a. The patient if he/she is of ages (18 years old and above) and	Dr. Aishah binti Masri, Head of Medico-legal & Medical Ethic Unit.	Dr. Nor Azlina binti Abdul Aziz, Hospital Director.

			of sound mind, OR b. If the patient is incapable of giving consent, in the case of a minor or does not have the mental capacity to make a sound decision, consent should be taken from patient's guardian / relative as defined in the Mental Health Act; "Relative" means any of the following persons of or above eighteen years of age: (a) husband or wife; (b) son or daughter; (c) father or mother; (d) brother or sister; (e) grandparent; (f) grandchild; (g) maternal or paternal uncle or aunt; (h) nephew or niece. "Guardian", in relation to a minor, means the parent or parents of the minor, or a person lawfully appointed by will or by an order of a competent Court to be the guardian of the minor, or a person who has lawful custody of the minor.		
6.	**22/11/2024**	**5.4 - rephrase sentence no ii**	ii. Services shall be given on an appointment basis except for Emergencies **and General Outpatient Department (removed)**	Dr. Haizul Ikhwan bin Murat, Head Of Ophthalmology Department, Chairman of Specialist Clinic	Dr. Nor Azlina binti Abdul Aziz, Hospital Director.

				Committee.	
7.	**22/11/2024**	**5.6** **- no vi new policy**	Examination of a female patient by a male doctor must be done in the presence of the chaperone, who is a medical personnel. This must be strictly observed for gynaecological and intimate examination. **(NEW POLICY)**	Dr. Haizul Ikhwan bin Murat, Head Of Ophthalmology Department, Chairman of Specialist Clinic Committee.	Dr. Nor Azlina binti Abdul Aziz, Hospital Director.
8.	**22/11/2024**	**5.7.1** **- rephrase no V change to new policy**	and the Revised Circulars" *'No. [44 dlm.KKM 203/20 Jld. 6] Panduan Perlaksanaan Perintah Fi [Perubatan] Pindaan 2003 – Caj Baru Bagi Pesakit Orang Asing'* **(REMOVED)** Perintah Fi [Perubatan] Pindaan 2003 – Caj Baru Bagi Pesakit Orang Asing' and Garis Panduan Pelaksanaan Perintah Fi (Perubatan) (Kos Perkhidmatan) 2014. **(NEW POLICY)**	En. Muhammad Aidid Bazli bin Bakri, Head of Finance, Accounting and Revenue Unit.	Dr. Nor Azlina binti Abdul Aziz, Hospital Director.
9.	**22/11/2024**	**5.9.1** **- no viii, xii, xiv, xviii and xix change policies**	viii. Hospital tag/wrist band shall not be removed during last office procedures, and all bodies shall be tagged with body identification tag. If Police cases, ward staffs shall make a note on the body identification tag. **(REMOVED)** viii. Hospital tag/wrist band shall remain with the body, and all bodies shall be tagged with body identification tag. If Police	Dr. Anwar Hakim bin Abdul Azmi, Head of Forensic Medicine Unit	Dr. Nor Azlina binti Abdul Aziz, Hospital Director.

			cases, ward staff shall make a note on the body identification tag. **(NEW POLICY)** xii**.** Upon receiving the body at mortuary, the forensic assistant medical officer on duty shall document all details pertaining to the deceased and as well as claimant of the body in the Death Registration Book **(REMOVED)** xii. Bodies received at mortuary and the claimants are recorded in the Death Registration Book **(NEW POLICY)** **xiv.** The forensic assistant medical officer is responsible for the release of the body from the mortuary to the claimants after verifying all relevant details pertaining to the deceased and claimants of the body. **(REMOVED)** xiv. All relevant details pertaining to the deceased and claimants of the body are verified prior to release of body. **(NEW POLICY)** xviii. The claimants shall make their own arrangement for the		

			process of performing the funeral rites in accordance with the respective religious bodies and transportation of the body. **(REMOVED)** xviii. The hospital does not provide any service or facility for the arrangement of last rites or funeral rites. **(NEW POLICY)** xix. Hospital only provides room facilities for the performance of the last rites by the claimants without incurring any charges. **(REMOVED)** **xix.** The hospital provides transportation services subject to availability of vehicle, and charges will be incurred as per stipulated guidelines. **(NEW POLICY)**		
10.	**22/11/2024**	**5.9.4 - no iii removed**	iii. The police shall decide the need for forensic post mortem examination. If forensic post mortem examination is required by Police for the purpose of their investigation, the Borang Permintaan Pemeriksaan Mayat, Polis 61 Pindaan 4/68 shall be issued by the investigating police officer. **(REMOVED)**	Dr. Anwar Hakim bin Abdul Azmi, Head of Forensic Medicine Unit	Dr. Nor Azlina binti Abdul Aziz, Hospital Director.

11.	**22/11/2024**	**5.9.5 - no i new policy**	i. Consent from the next of kin must be obtained by the requesting team and must refer the case to the Histopathologist on duty at Hospital Tengku Ampuan Afzan, Kuantan. **(REMOVED)** i. Consent from the next of kin must be obtained by the requesting team and must refer the case to the anatomical pathologist on duty. If the postmortem examination is not consented by the next of kin, the clinician may certify death with the closest diagnosis as the likely cause of death. If there is no clear working diagnosis, the cause of death may be written as "undetermined" or "unascertained". **(NEW POLICY)**	Dr. Anwar Hakim bin Abdul Azmi, Head of Forensic Medicine Unit	Dr. Nor Azlina binti Abdul Aziz, Hospital Director.
12.	**22/11/2024**	**5.13 - PAIN FREE PROGRAM**	The policy has been implemented at all level in the hospital. The objectives include providing holistic patient care, giving effective treatment and ensuring patient's satisfactory towards our service. There are two components in our Pain Service that includes Acute Pain Service and Chronic Pain Service.	Dr. Rachel Shyamala A/P K.C.Chackoo, Hospital Deputy Director II (Medical), Chairman Pain Free Program Committee.	Dr. Nor Azlina binti Abdul Aziz, Hospital Director.

			4.1.1 P5VS Implementation • Using Pain Assessment Chart in monitoring all the patients' vital signs • Continuous education and training to all medical staff involved • All the modules used during training and policy are comply to one as provided by MOH • An audit at hospital level is being held regularly to ensure the effectiveness of the implementation **(REMOVED)** **CHANGE TO A NEW POLICY**		
13.	**22/11/2024**	**5.14.2 - no iii new policy**	iii. Prescription from other Ministry of Health hospitals and clinics without referral by the pharmacy department and prescription from other government facilities shall be endorsed and re-prescribed by the hospital specialist in-charge before prescription is filled, subject to availability of drugs. **(NEW POLICY)**	Pn. Rohaya binti Sulaiman, Head of Pharmacy Department.	Dr. Nor Azlina binti Abdul Aziz, Hospital Director.
14.	**22/11/2024**	**5.14.3 - no iv removed**	Urgent needs for inpatients shall be met by the pharmacy personnel on call **(REMOVED)**	Pn. Rohaya binti Sulaiman, Head of Pharmacy Department.	Dr. Nor Azlina binti Abdul Aziz, Hospital Director.

15.	**22/11/2024**	**5.14.5 -new policy**	<u>Sedation</u> i. Hospital shall provide safe procedure for all patient and done by trained personal. **(NEW POLICY)**	Pn. Rohaya binti Sulaiman, Head of Pharmacy Department.	Dr. Nor Azlina binti Abdul Aziz, Hospital Director.
16.	**22/11/2024**	**5.15 - no viii and ix new policies**	viii. Clean, decontaminate and sterilize loaned instrumentation at the receiving facility. All consignment set should be delivered to the designated area (decontamination) in the CSSU. **(NEW POLICY)** ix. Obtain manufacturer's written IFU (Instruction For Use) before the loaned items are received. Vendor should provide manual instruction cleaning process and sterilization. Determine responsibility for ensuring the set weight no more than 25 pounds (11.3 kg). **(NEW POLICY)**	Pn. Azimah binti Abu Samah, Nurse Supervisor, Head of CSSD Unit.	Dr. Nor Azlina binti Abdul Aziz, Hospital Director.
17.	**22/11/2024**	**5.17.1 - no ix rephrase of sentences**	ix. "Pekeliliking KPK Bil. 17/2010: Garispanduan Pengendalian Dan Pengurusan Rekod Perubatan Pesakit bagi Hospital- Hospital dan Institusi Perubatan" **(REMOVED)** ix. Garis Panduan Pengendalian dan	Pn. Kang Chui Huai, Head of Medical Record Unit	Dr. Nor Azlina binti Abdul Aziz, Hospital Director.

			Pengurusan Rekod Perubatan Pesakit Di Fasiliti KKM(2023)" **(NEW POLICY)**		
18.	**22/11/2024**	**5.17.4** **- no i change to a new policy** **- no vi removed**	i. Medical board is established under ten (10) circumstances, according to Pekeliling Ketua Pengarah Kesihatan bil 3/2017 **(REMOVED)** i. Existing guideline 'Pekeliling KPK Bil 13/2017 : "Garis Panduan Penubuhan Lembaga Perubatan di Fasiliti KKM" shall be complied in the preparation of medical board report. **(NEW POLICY)** vi. The application for Medical Board shall be charged in accordance to the Fees Act 1982. The charge is RM 200. **(REMOVED)**	Pn. Kang Chui Huai, Head of Medical Record Unit	Dr. Nor Azlina binti Abdul Aziz, Hospital Director.
19.	**22/11/2024**	**6.1** **- no vi removed**	vi. All clients requiring services in the clinic must be furnished with the relevant document to facilitate appointment scheduling and registration e.g. referral letter, appointment card, guarantee letter *(e-GL)* etc **(REMOVED)**	Dr. Haizul Ikhwan bin Murat, Head Of Ophthalmology Department, Chairman of Specialist Clinic Committee.	Dr. Nor Azlina binti Abdul Aziz, Hospital Director.

20.	**22/11/2024**	**6.6** **- Laboratory change to a new policy**	6.6 Laboratory and Blood Transfusion Service **(NEW POLICY)**	Dr. Nor Suhaila binti Mat Riffin, Head of Pathology Department	Dr. Nor Azlina binti Abdul Aziz, Hospital Director.
21.	**22/11/2024**	**9.0** **- no ix new policy**	ix. All research shall adhere to current guideline for conducting research in Ministry of Health (MOH) institutions and facilities by National Institutes of Health (NIH). **(NEW POLICY)**	Dr. Mohd Zuraimi bin Mohammed Zohdi, Head of Quality Unit	Dr. Nor Azlina binti Abdul Aziz, Hospital Director.
22.	**22/11/2024**	**10.2.1** **- no ii new policy**	ii. Requirement of medical equipment shall be decided by the individual department/unit and coordinated by the procurement unit. **(NEW POLICY)**	Pn. Rohaya binti Sulaiman, Head of Pharmacy Department.	Dr. Nor Azlina binti Abdul Aziz, Hospital Director.
23.	**22/11/2024**	**10.2.2** **- no iii removed sentence**	iii. store except for chemical reagent, which shall be sent directly to Pathology department. **(REMOVED)**	Pn. Rohaya binti Sulaiman, Head of Pharmacy Department.	Dr. Nor Azlina binti Abdul Aziz, Hospital Director.
24.	**22/11/2024**	**11.1** **- removed Fax** **- no vii, viii and ix removed**	vii. Fax facilities shall be provided in identified areas to be shared between department and units **(REMOVED)** viii. Fax shall be used only when there is an urgency to send a letter or document and its use shall be monitored **(REMOVED)** ix. Fax machine placed in main management office, record office, emergency department and *Unit Hasil*	Pn. Ainun Zulaikha binti Ahmad Zani, Head of Public Relations Unit.	Dr. Nor Azlina binti Abdul Aziz, Hospital Director.

			(REMOVED)		
25.	**22/11/2024**	**13.1** **- rephrase no vi**	vi. **by the police (removed)** vi. by the **Kementerian Dalam Negeri or PDRM (NEW WORDS)**	En. Muhamad Rukman bin Mohd Lazim, Head of Security Unit.	Dr. Nor Azlina binti Abdul Aziz, Hospital Director.
26.	**22/11/2024**	**15.0** **- no iv new policy**	iv. Protect official secret information (maklumat rahsia rasmi) and government official information (maklumat rasmi kerajaan) from unauthorized access. **(NEW POLICY)**	Pn. Mazyana binti Mohamad, Head of Information Technology Unit.	Dr. Nor Azlina binti Abdul Aziz, Hospital Director.
27.	**14/1/2025**	**2.2** **-new Policy**	**Hospital Vision & Mission** **Vision** To become a global leader in healthcare services, driven by expertise, digital innovation, and holistic care to enhance community well-being. **Mission** 1. To deliver expertise-based healthcare services. 2. To foster clinical, digital, and research excellence. 3. To optimize resources, facilities, and digital infrastructure. 4. To enhance patient experience through digital transformation. 5. To lead cluster collaboration and digital innovation.	Dr. Nur Azlina binti Mohammad Hashim, Hospital Deputy Director I (Medical)	Dr. Nor Azlina binti Abdul Aziz, Hospital Director.

			Objective 1. To improve clinical service quality and patient safety. 2. To integrate digital technology into healthcare services. 3. To empower coordination and collaboration within the cluster. 4. To drive digital-based innovation and research. 5. To enhance patient experience through a digital-first approach. 6. To strengthen digital capabilities and skills of staff. 7. To optimize resource management through digital solutions. Hospital Mission, Vision and Objective will be reviewed every 3 years or when there is a change of Hospital Director.		
28.	**14/3/2025**	**5.21** **-Cluster Programme**	**NEW POLICY**	Dr Mohamad Faqih bin Mohamad Puzi, Head of Cluster Unit	Dr. Nor Azlina binti Abdul Aziz, Hospital Director.
29.	**14/3/2025**	**3.1** **-Hospital Organization Chart**	**UPDATED**	En Hazlan bin Sulaiman, Hospital Deputy Director (Administration)	Dr. Nor Azlina binti Abdul Aziz, Hospital Director.
30.	**14/3/2025**	**11.3** **- no ii replace words**	Yellow alert change to Code Orange	En. Shaipullizam bin Mohamed Head of AMO Supervision Unit	Dr. Nor Azlina binti Abdul Aziz, Hospital Director.

CONTENTS

NUM	CONTENT	PAGE
1.	**PREAMBLE**	1
2.	**VISION & MISSION**	
	2.1 MOH Vision & Mission	2
	2.2 Hospital Vision & Mission	3
3.	**ORGANISATION**	
	3.1 Hospital Organization Chart	5
	3.2 Organizational Aspects	7
	3.3 Hospital Overview	8
	3.4 Committees	18
4.	**CORPORATE GOVERNANCE**	
	4.1 General Administration	20
	4.2 Finance	23
	4.3 Revenue Collection (Hospital Revenue)	25
	4.4 Human Resource	27
	4.5 Hospital Safety and Security	32
	4.6 Public Relations and Media Management (Public Relations)	37
	4.7 Board of Visitors	41
	4.8 Transport System	42
	4.9 Visiting Hours	42
	4.10 Traffic Control	46
5.	**CLINICAL GOVERNANCE**	
	5.1 Patients and Families’ Rights	48
	5.2 Consent	50
	5.3 Counter Services	52
	5.4 Appointment and Scheduling	53
	5.5 Registration	53

	5.6 Consultation	54
	5.7 Admission	55
	5.8 Discharge	60
	5.9 Mortuary Service	62
	5.10 Referral System	68
	5.11 Documentation of Clinical Care	71
	5.12 Procedure and Surgery	72
	5.13 Pain Free Program	73
	5.14 Drug and Medication	78
	5.15 Sterilization and Disinfection	80
	5.16 Infection Control	81
	5.17 Management of Medical Records and Reports	82
	5.18 Health Education	85
	5.19 Ethics and Law	85
	5.20 Organ and Tissue Donation	86
	5.21 Cluster Programme	86
6.	**MEDICAL FACILITIES**	
	6.1 Specialist Clinics	94
	6.2 Emergency and Trauma Department	95
	6.3 Day Care	96
	6.4 Operation Theatre	97
	6.5 Intensive Care (Critical Care)	98
	6.6 Laboratory and Blood Transfusion Services	100
7.	**QUALITY MANAGEMENT**	
	7.1 Standard & Indicators	103
	7.2 Quality Improvement Activities	103
8.	**TRAINING**	
	8.1 Continuous Professional Development (CPD) Programme	105
	8.2 Credentialing & Privileging	105
	8.3 House Officers and Other Post-Basic/Graduate Training	106

9.	**RESEARCH**	107
10.	**SUPPLIES AND ASSETS**	
	10.1 Procurement	109
	10.2 Equipment and Pharmaceutical Supplies	109
11.	**COMMUNICATION SYSTEM**	
	11.1 Telephones	113
	11.2 Nurse Call System	114
	11.3 Public Address System	114
12.	**HOSPITAL AMENITIES**	
	12.1 Car Park	115
	12.2 Staff Facilities	115
	12.3 Public Facilities	116
13.	**PRIVATISED SERVICES**	
	13.1 Security Services	117
	13.2 Outsourced Catering Services	119
	13.3 Hospital Support Service	120
14.	**DISASTER MANAGEMENT**	
	14.1 Disaster Plan	123
	14.2 Hospital Evacuation	124
	14.3 Specific Contingency Plans	125
15.	**INFORMATION AND COMMUNICATION TECHNOLOGY (ICT)**	126
16.	**BUSINESS CONTINUITY PLAN FOR HIS SYSTEM DOWN**	127
17.	**PLANNING AND DEVELOPMENT**	128

1. PREAMBLE

General Hospital Operational Policy

Specific statement of intent and direction in order to meet the function of the hospital.

Purpose

The purpose of this document is primarily to assist and facilitate hospital management team to effectively manage the Ministry of Health (MOH) hospitals. General Hospital Operational Policy is a specific statement of intent and direction to meet the functions of the hospital. To achieve the objectives of the hospital, the policies cut across the whole organization with a scope that shall cover 4 main components of the hospital i.e. people, technology, work process and structure.

2. VISION & MISSION

2.1 MOH Vision & Mission

Vision

A nation working together for better health.

Mission

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

i) To facilitate and support the people to:

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

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

- Customer centered.
- Equitable.
- Affordable.
- Efficient.
- Technologically appropriate.
- Environmentally adaptable.
- Innovative.

ii) With emphasis on:

- Quality.
- Innovation.
- Health.
- Promotion.
- Respect for human dignity.

iii) Promotes individual responsibility and community participation towards an enhanced quality of life.

2.2 Hospital Vision & Mission

Vision

To become a global leader in healthcare services, driven by expertise, digital innovation, and holistic care to enhance community well-being.

Mission

1. To deliver expertise-based healthcare services.

2. To foster clinical, digital, and research excellence.

3. To optimize resources, facilities, and digital infrastructure.

4. To enhance patient experience through digital transformation.

5. To lead cluster collaboration and digital innovation.

Objective

1. To improve clinical service quality and patient safety.
2. To integrate digital technology into healthcare services.
3. To empower coordination and collaboration within the cluster.
4. To drive digital-based innovation and research.
5. To enhance patient experience through a digital-first approach.
6. To strengthen digital capabilities and skills of staff.
7. To optimize resource management through digital solutions.

Hospital Mission, Vision and Objective will be reviewed every 3 years or when there is a change of Hospital Director.

3. ORGANISATION

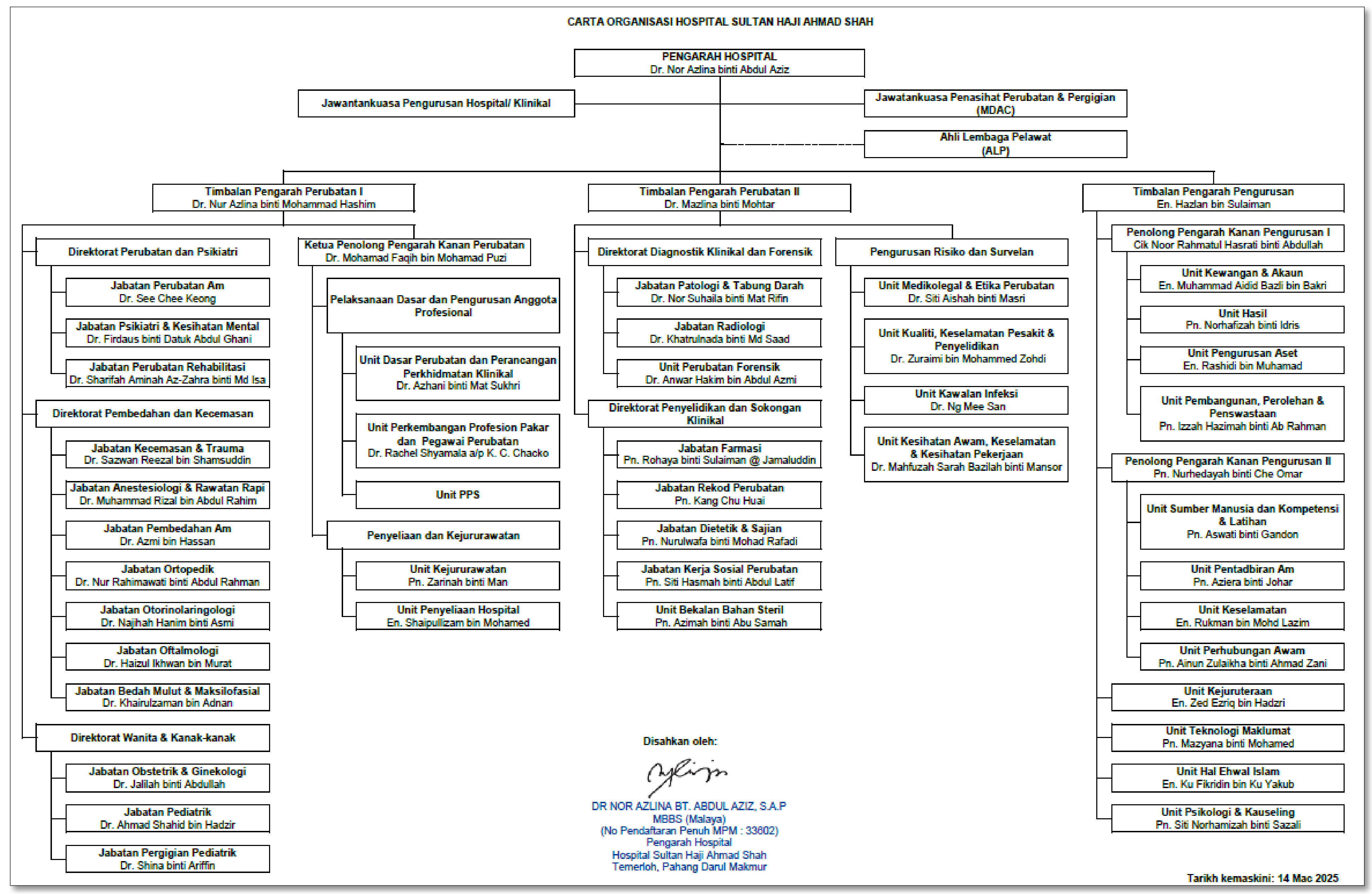
3.1 Hospital Organization Chart

Chart has been designed according to State Specialist Hospital. Designated with: -

(1) Director

(2) Deputy Directors

- Clinical Supervision
- Clinical Management
- Management


CARTA ORGANISASI HOSPITAL SULTAN HAJI AHMAD SHAH
PENGARAH HOSPITAL
Dr. Nor Azlina binti Abdul Aziz
Jawantankuasa Pengurusan Hospital/ Klinikal
Jawatankuasa Penasihat Perubatan & Pergigian (MDAC)
Ahli Lembaga Pelawat (ALP)
Timbalan Pengarah Perubatan I
Dr. Nur Azlina binti Mohammad Hashim
Timbalan Pengarah Perubatan II
Dr. Mazlina binti Mohtar
Timbalan Pengarah Pengurusan
En. Hazlan bin Sulaiman
Direktorat Perubatan dan Psikiatri
Jabatan Perubatan Am
Dr. See Chee Keong
Jabatan Psikiatri & Kesihatan Mental
Dr. Firdaus binti Datuk Abdul Ghani
Jabatan Perubatan Rehabilitasi
Dr. Sharifah Aminah Az-Zahra binti Md Isa
Direktorat Pembedahan dan Kecemasan
Jabatan Kecemasan & Trauma
Dr. Sazwan Reezal bin Shamsuddin
Jabatan Anestesiologi & Rawatan Rapi
Dr. Muhammad Rizal bin Abdul Rahim
Jabatan Pembedahan Am
Dr. Azmi bin Hassan
Jabatan Ortopedik
Dr. Nur Rahimawati binti Abdul Rahman
Jabatan Otorinolaringologi
Dr. Najihah Hanim binti Asmi
Jabatan Oftalmologi
Dr. Haizul Ikhwan bin Murat
Jabatan Bedah Mulut & Maksilofasial
Dr. Khairulzaman bin Adnan
Direktorat Wanita & Kanak-kanak
Jabatan Obstetrik & Ginekologi
Dr. Jalilah binti Abdullah
Jabatan Pediatrik
Dr. Ahmad Shahid bin Hadzir
Jabatan Pergigian Pediatrik
Dr. Shina binti Ariffin
Ketua Penolong Pengarah Kanan Perubatan
Dr. Mohamad Faqih bin Mohamad Puzi
Pelaksanaan Dasar dan Pengurusan Anggota Profesional
Unit Dasar Perubatan dan Perancangan Perkhidmatan Klinikal
Dr. Azhani binti Mat Sukhri
Unit Perkembangan Profesion Pakar dan Pegawai Perubatan
Dr. Rachel Shyamala a/p K. C. Chacko
Unit PPS
Penyeliaan dan Kejururawatan
Unit Kejururawatan
Pn. Zarinah binti Man
Unit Penyeliaan Hospital
En. Shaipullizam bin Mohamed
Direktorat Diagnostik Klinikal dan Forensik
Jabatan Patologi & Tabung Darah
Dr. Nor Suhaila binti Mat Rifin
Jabatan Radiologi
Dr. Khatrulnada binti Md Saad
Unit Perubatan Forensik
Dr. Anwar Hakim bin Abdul Azmi
Direktorat Penyelidikan dan Sokongan Klinikal
Jabatan Farmasi
Pn. Rohaya binti Sulaiman @ Jamaluddin
Jabatan Rekod Perubatan
Pn. Kang Chu Huai
Jabatan Dietetik & Sajian
Pn. Nurulwafa binti Mohad Rafadi
Jabatan Kerja Sosial Perubatan
Pn. Siti Hasmah binti Abdul Latif
Unit Bekalan Bahan Steril
Pn. Azimah binti Abu Samah
Pengurusan Risiko dan Survelan
Unit Medikolegal & Etika Perubatan
Dr. Siti Aishah binti Masri
Unit Kualiti, Keselamatan Pesakit & Penyelidikan
Dr. Zuraimi bin Mohammed Zohdi
Unit Kawalan Infeksi
Dr. Ng Mee San
Unit Kesihatan Awam, Keselamatan & Kesihatan Pekerjaan
Dr. Mahfuzah Sarah Bazilah binti Mansor
Penolong Pengarah Kanan Pengurusan I
Cik Noor Rahmatul Hasrati binti Abdullah
Unit Kewangan & Akaun
En. Muhammad Aidid Bazli bin Bakri
Unit Hasil
Pn. Norhafizah binti Idris
Unit Pengurusan Aset
En. Rashidi bin Muhamad
Unit Pembangunan, Perolehan & Penswastaan
Pn. Izzah Hazimah binti Ab Rahman
Penolong Pengarah Kanan Pengurusan II
Pn. Nurhedayah binti Che Omar
Unit Sumber Manusia dan Kompetensi & Latihan
Pn. Aswati binti Gandon
Unit Pentadbiran Am
Pn. Aziera binti Johar
Unit Keselamatan
En. Rukman bin Mohd Lazim
Unit Perhubungan Awam
Pn. Ainun Zulaikha binti Ahmad Zani
Unit Kejuruteraan
En. Zed Ezriq bin Hadzri
Unit Teknologi Maklumat
Pn. Mazyana binti Mohamed
Unit Hal Ehwal Islam
En. Ku Fikridin bin Ku Yakub
Unit Psikologi & Kauseling
Pn. Siti Norhamizah binti Sazali
Disahkan oleh:
DR NOR AZLINA BT. ABDUL AZIZ, S.A.P
MBBS (Malaya)
(No Pendaftaran Penuh MPM : 33802)
Pengarah Hospital
Hospital Sultan Haji Ahmad Shah
Temerloh, Pahang Darul Makmur
Tarikh kemaskini: 14 Mac 2025

3.2 Organizational Aspects

i. The hospital shall be headed by a Hospital Director who is responsible for the overall management of the hospital. The Hospital Director supported by the heads of the clinical and non clinical departments/units. The Hospital Director shall be a Medical Doctor.

ii. All clinical departments/units will be headed by resident specialists or medical officers in the absence of specialists, the non clinical departments shall be headed by officers trained in the respective disciplines.

iii. The nursing services shall be headed by a matron or nursing sister, in the absence of a matron by. She/he shall also be responsible for areas such as CSSD, laundry and linen services, infection control and nurse's hostel

iv. The hospital supervisors shall be responsible for coordinating the services provided by the assistant medical officers. In addition, he/she shall be responsible for the services such as ambulance, transport and portering services.

v. The administrative services shall be headed by the administrative officer in areas related to general administration, finance, revenue and security.

vi. The engineering services shall be headed by an engineer aided by technical assistants and technicians. They shall be responsible for ensuring areas related to privatized services for example hospital waste management, fire safety and maintenance of grounds, landscaping, maintenance and repair of all civil, mechanical, electrical and biomedical installations are appropriately looked after by the private company.

3.3 Hospital Overview

Background:

Hospital Sultan Haji Ahmad Shah, Temerloh (HoSHAS) formerly known as Hospital Temerloh was built to replace Hospital Mentakab. HoSHAS was formally launched on 27 Mac 2006 by KDYMM Al-Marhum Sultan Haji Ahmad Shah Al-Musta'in Billah Ibni Al-Marhum Sultan Abu Bakar Ri'ayatuddin Al-Muadzam Shah after one year of operation.

HoSHAS is located in the middle of Kuala Lumpur Highway – Kuantan and located at the centre of Negeri Pahang. The construction of HoSHAS was built on the 44 acres of land and it cost RM498 million. Now, HoSHAS is increasing its service delivery by using Hospital Information System (HIS) to ensure the quality and prompt of service provided.

Facilities available:

1. Hospital Quarters

Hospital quarters were built to ensure the right staffs are given the comfortable and moneysaving housing. It eases the hospital staff to go to work especially if they are scheduled to on-call duty and any emergency cases.

- Located in the compound of Hospital Sultan Haji Ahmad Shah, Temerloh
- 4 types of quarters available: A, B, C and D which consist of 3 blocks : B, C and D
  In total there are 260 houses available for the qualified staff;
  (For House Officer: Block A consists of 60 rooms)
  (For Medical Officer: Block B consists of 42 rooms)
  (For Specialist: Block C consists of 10 rooms)
  (For Supportive staff: Block D consist of 148 rooms, divided to Block F & Block G)
- The staff quarters are managed and maintained under the Supervision of General Administration Unit.

2. Nurses Hostel

- Located in the Hospital Sultan Haji Ahmad Shah, Temerloh compound
- Consist of 100 rooms named Block E (80 big rooms & 20 small rooms)
- Supervised by Hostel Supervisor under the General Administration Unit

3. Cafeteria

- Cafeteria provides variety foods and beverages for the staffs, patients and visitors which operate from 6.30 a.m. to 10.00 p.m.
- Cafeteria's contract is managed by Development Unit

4. Other Facilities

For staff convenience, patients and visitors other facilities are available in the hospital such as:-

- Pusat Islam
- ATM Machine
- Breast feeding room
- Information centre/Query counter
- Kiosks - Supply souvenir
- Mini-market - Variety of goods, packed foods and beverages
    - Cosmetic and toiletries
    - Simple medical equipment
    - Disposable medical item

SERVICES PROVIDED

CLINICAL SERVICES

General Medicine	Emergency & Trauma	Paediatrics Dentistry
Paediatrics	Anaesthesiology	Otorhinolaryngology
Obstetrics & Gynaecology	Psychiatrics	Ophthalmology
Orthopedics	Oral Surgery	General Surgery

CLINICAL SUPPORT SERVICES

Pharmacy & Medical Store	Hospital Supervisory & Nursing	CSSD
Dietetic & Food Services	Quality & Research	Pathology
Medical Social Work	Radiology	Rehabilitation (Physiotherapy & Occupational Therapy)
Health Education	Psychology Counseling	Medical Record

OUT-PATIENT

Daycare Unit	Hemodialysis Unit
Specialist Clinic	Emergency & Trauma Department

INTENSIVE CARE

Critical Unit	Burn Unit
Intensive Care Unit	Neonatal Intensive Care Unit
High Dependency Ward	

MANAGEMENT

General Administration	Library
Financial & Revenue	Human Resource
Information Technology & Communication	Development, Procurement & Privatization

PRIVATISATION & SECURITY SUPPORT SERVICES

Linen Management	Security
Facility Engineering	Cleansing
Healthcare Clinical Waste Management	Biomedical Engineering

VISITING SPECIALIST

Beside of the internal specialist services, HoSHAS also provides sub-specialist from other nearest hospitals. The sub-specialists are as follows:-

DISCIPLINES	VISITING SPECIALIST
General Medicine	Dermatology
	Gastroenterology
	Haematology
	Infectious Disease
	Cardiology
	Neuromedical
General Surgery	Plastic Surgery
	Paediatric Surgery
	Hepatobiliary
	Oncology

Orthopaedic	Paediatric orthopaedic
	Spine
	Foot & Ankle
	Arthroplasty
	Sports Surgery & Arthroscopy
Obstetrics & Gynaecology	Materno-Feto Medicine
	Gynae-Oncology
	Urogynaecology
	Infertility
Paediatric	Cardiology
	Respiratory
	Nephrology
	Nuerology
Psychiatry	Child & Adolescent Psychiatry
	Consultation Liaison Psychiatry
Ophthalmology	Glaucoma
	Oculoplastic

STAFFING 2021

CATEGORY	APPROVED	FILLED	VACANCY	% PLACEMENT
SPECIAL GRADE	4	2	2	50%
MANAGERIAL & PROFESSIONAL	401	369	32	92%
PARAMEDIC & AUXILIARY	1286	1261	25	98%
COMMON AND SUPPORT	516	497	19	96.3%
TOTAL	2207	2129	78	96.46%

STAFFING 2022

CATEGORY	APPROVED	FILLED	VACANCY	% PLACEMENT
SPECIAL GRADE	3	1	2	33.30%
MANAGERIAL & PROFESSIONAL	448	362	86	80.80%
PARAMEDIC & AUXILIARY	1286	1261	25	98%
COMMON AND SUPPORT	515	488	26	94.75%
TOTAL	2252	2112	139	93.78%

STAFFING 2023

CATEGORY	APPROVED	FILLED	VACANCY	% PLACEMENT
SPECIAL GRADE	3	3	0	100%
MANAGERIAL & PROFESSIONAL	455	410	45	90.10%
PARAMEDIC & AUXILIARY	1286	1248	38	97.04%
COMMON AND SUPPORT	515	486	29	94.36%
TOTAL	2259	2147	112	95.04%

STAFFING 2024

CATEGORY	APPROVED	FILLED	VACANCY	% PLACEMENT
SPECIAL GRADE	3	3	0	100%
MANAGERIAL & PROFESSIONAL	454	405	49	89.20%
PARAMEDIC & AUXILIARY	1286	1231	55	95.72%
COMMON AND SUPPORT	515	486	29	94.36%
TOTAL	2258	2125	133	94.10%

ACHIEVEMENTS

NO.	NAME OF ACHIEVEMENTS / CERTIFICATE / RECOGNITION	DATE OF CERTIFICATION /RECOGNITION	VALID UNTIL
1.	PSYCHIATRY DEPARTMENT - ARTICLES – CHALLENGES IN MANAGING CEREBAL PALSY PATIENT WITH BRIEF PSYCHOTIC DISORDER: A CASE REPORT	MALAYSIAN JOURNAL OF PUBLIC HEALTH MEDICINE, VOLUME 22 (SUPPL (2) 2022) -2	
2.	PSYCHIATRY DEPARTMENT - REDUCING THE NUMBER OF FALLS PSYCHIATRY INPATIENT, HOSHAS TEMERLOH	Q BULETIN, VOL. 1, NO. 31 (SUPPLEMENT 1), JAN – DEC 2022	
3.	PSYCHIATRY DEPARTMENT - 2ND PLACE – PERTANDINGAN QA PERINGKAT JKNP 2022	MAY	

4.	OFTALMOLOGI DEPARTMENT – 2ND PRIZE WINNER (POSTER) – REFRACRTIVE SURPRISE IN PATIENTS UNDERGO CATARACT SURGERY IN HOSHAS IN 2021	11 OCTOBER 2022	
5.	OFTALMOLOGI DEPARTMENT – 2ND PRICE WINNER (CASE REPORT) – PAEDIATRIC RETROBULBAR OPTIC NEURITIS: CASE STUDY	11 OCTOBER 2022	
6.	OFTALMOLOGI DEPARTMENT – 3RD PRICE WINNER (CASE REPORT) – CILLIARY BODY MELANOMA : A RARE OCULAR MALIGNANCY	11 OCTOBER 2022	
7.	OFTALMOLOGI DEPARTMENT – CONSOLATION PRIZE – POSTERIOR CAPSULAR RENT IN PATIENTS UNDERGOING CATARACT SURGERY IN HOSHAS	2021	
8.	KARNIVAL KATARAK HOSHAS OLEH JABATAN OFTALMOLOGI – BERJAYA MELAKUKAN 120 PEMBEDAHAN MATA DALAM 4 HARI	22 AUGUST 2022	25 AUGUST 2022
9.	MS ISO 15199 (EXTENSION OF BRANCH) – PATOLOGI SERVICES HOSPITAL CLUSTER PAHANG TENGAH – LEAD HOSPITAL	2023	2028
10.	MALAYSIAN SOCIETY FOR QUALITY IN HEALTH (MSQH)	2019 – 2023	

11.	CERTIFICATE FROM GOOD MANUFACTURING SERVICES ATAU GMP MALAYSIA (AMALAN PERKILANGAN BAIK)	16 JANUARY 2024	25 January 2027
12.	CERTIFICATE FROM HAZARD ANALYSIS CRITICAL CONTROL POINT (HACCP) – FOOD SAFETY ASSURANCE SYSTEM	16 JANUARY 2024	25 January 2027
13.	CERTIFICATE FROM MAKANAN SELAMAT TANGUNGGJAWAB INDUSTRI (MeSTI)	16 JANUARY 2024	25 January 2027
14.	HOSPITAL MESRA IBADAH (HMI) – 5 STAR	16 MAY 2024	15 MEI 2027
15.	PAIN FREE HOSPITAL – TRANSFORMASI KONSEP RAWATAN PELANGGAN BEBAS KESAKITAN	21 AUGUST 2024	20 AUGUST 2028
16.	PERSIJILAN HALAL JABATAN DIET DAN SAJIAN	1 SEPTEMBER 2024	31 AUGUST 2026
17.	HOSPITAL RAKAN BAYI	10 NOVEMBER 2024	9 NOVEMBER 2027
18.	1ST PLACE – COMPETITION IN POINT-OF-CARE ULTRASOUND COMPETITION (MASTER SCAN) NATIONAL LEVEL (UNIVERSITY OF SAINS MALAYSIA) – JABATAN KECEMASAN & TRAUMA	12 JUNE 2024	
19.	WINNER 1ST PLACE – PERTANDINGAN INOVASI & INISIATIF PROGRAM 3R (REUSE, REDUCE, RECYCLE) 2024	21 OCTOBER 2024	

20.	3RD PLACE – PENCAPAIAN PRESTASI PENJIMATAN TENAGA HOSPITAL (2015 – 2024)	21 OCTOBER 2024	
21.	ANUGERAH PENCAPAIAN TERBAIK INISIATIF SARINGAN KESIHATAN KEBANGSAAN (NHSI) (BAHAGIAN PERUBATAN)	2024	

FUTURE PLANNING SERVICES

1) To have Histopathology Service in Hospital Sultan Haji Ahmad Shah, Temerloh.
2) To have Surgical Service in Hospital Jengka.
3) To have Medical drone Delivery in Hospital Sultan Haji Ahmad Shah, Temerloh
4) To develop a mobile application for self registration in Specialist Clinic.
5) To have Infection Disease Department in Hospital Jerantut.

FUTURE PLANNING FOR PHYSICAL DEVELOPMENT

NO.	ISSUE	PLANNING
1.	**O&G:** Antenatal and Postnatal ward are located far away from Labor Room and NICU	To build up 5 stories building to centralize the O&G and Neonatal
2.	**Pediatric :** Unavailability of ICU care beds in pediatric ward	Upgrading Pediatric Intensive Care Unit (PICU) with 5 beds – *already approval, waiting for budget RMK-12 allocation*
3.	**Anesthesiology** : Unavailability of isolation room in ICU ward	Upgrading the ICU 1 & 2 with Isolation room
4.	**Dietetics**: Service interrupted due to damages drain and floor	Upgrading kitchen with high quality drain and floor

5.	**Medical Record**: Unavailability of fire detection system in all medical record room	Upgrading medical record room with smoke detector, fire alarm system and water sprinkler
6.	**Forensic**: Non-conducive ventilation system	Upgrading current autopsy room to autopsy bio safety level 2 (BSL 2)
7.	**Psychiatric**: Patient safety issue where some safety door and windows are broken	Upgrading Wad Kenanga 9 with new high quality safety door and mirror windows
8.	**Orthopedic**: Mixture of dust in the air that could lead to staff and patient safety issue	To install a dust hood collector system in pop room
9.	**Management:** Slope movement that can cause landslides and service interruption at Rehabilitation area	Reconstruct and repair the slope

3.4 Committees

i. The hospital shall establish a Management Committee, a Medical and Dental Advisory Committee and several other committees as required by the Ministry of Health or the Central Agency.

ii. A management committee chaired by the director shall discuss management issues (such as service expansion, standard operating procedure) and makes decision on resource allocation and distribution.

iii. Clinical matters shall be discussed at the Medical and Dental Advisory Committee (MDAC), whose members are representatives from the various clinical directorates and chaired by the specialists. MDAC shall function as a ‘clinical advisor’ to the management committee with regards to clinical governance.

iv. All committees shall be chaired by the hospital director or an officer appointed by the director unless stated otherwise by the MOH Guidelines. The members shall consist of officers from relevant departments and units. Each committee shall have its own terms of reference. All committee shall report to hospital management committee.

4. CORPORATE GOVERNANCE

Definition and Purpose of Corporate Governance

Corporate governance is a term that refers broadly to the rules, processes or laws by which businesses are operated, regulated and controlled. The term can refer to internal factors defined by the officers, stockholders or constitution of a corporation as well as to external forces such as consumer groups, clients and government regulations.

It provides a structure that, works for the benefit of everyone in the organization by ensuring that the enterprise adheres to the accepted ethical standards and best practices as well as to formal laws.

4.1 General Administration

4.1.1 Letters and Documents

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

ii. The hospital shall have a common and systematic hospital using Digital Document Management System (DDMS) of all official/confidential letters/documents. Both incoming and outgoing letters shall be scanned and filed accordingly in the system.

iii. Incoming official/confidential letters/documents shall be registered, scanned and sent to respective department/unit within specified time through official emails. Urgent letters/documents shall be sent immediately and the respective department/unit informed/updated by phone.

iv. All personal letters/documents will be put in the separate pigeon hole according to each department/unit (the respective person advisable to get it by themselves) *hospital will not be responsible for any lost.

v. All outgoing official/confidential letters/documents shall use the standard letterhead of the hospital. Letters for internal circulation shall be circulated as Memo. All valid service circulars shall be adhered accordingly

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

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

viii. Letters/documents encouraged/allowed to be sent/received via official valid mail address link (moh.gov.my) as computerized hospital.

ix. Notification of letters/documents shall be sent/received via official valid short message sending @ ‘sms’/‘infoblast’ services.

4.1.2 Office Equipment and Supplies

- The General Administration Unit shall coordinate the requirement of office equipment e.g. stationeries of the hospital and distribution to the respective departments/units.

- The departments/units head shall propose an officer in charge to be designated by Hospital Director to be responsible for maintaining the asset and inventory list and to ensure proper use of equipment and supplies done.

- Certain office equipment shall be shared among several departments/units. Shared equipment shall be under the responsibility of the each respective departments/units where the equipment is/are located.

- The *"Pekeliling Perbendaharaan – AM1.1 Pengurusan Aset Kerajaan, AM2.1 – 2.9 Tatacara Pengurusan Aset Alih Kerajaan, AM 6 Tatacara Pengurusan Stor Kerajaan and AM 7 Tatacara Pengurusan Aset Tak Ketara Kerajaan*" shall be adhered to. The hospital Asset Management Unit / Committee shall be responsible for the flowing functions i.e. receiving, registering, usage, safekeeping, inspection, maintenance and disposal.

4.1.3 <u>Meeting Room Facilities</u>

- The use of meeting rooms and other facilities like auditorium and seminar rooms shall be coordinated accordingly. The designated person from General Administration responsible for coordinating these services with application form which is available in the official valid link in IT system.

- Policy for maintenance of the all the meeting/conference rooms should be officially done & maintained by the person in charge from administrative department.

- Meetings shall be well organized and documented. Call letters shall be sent out well in advance and minutes of meeting shall be sent out within specified time. A copy of the minutes shall be kept in the relevant file.

- The facilities provided depending on accumulation of group capacity;
  - Auditorium (280 people)
  - Seminar Room Orkid & Tanjung (80 people)
  - Seminar Room Teratai & Kiambang (60 people)
  - Conference Room Anggerik (35 – 50 people)
  - Meeting Room Seroja (20 – 25 people)
  - Meeting Room Cempaka (20 – 25 people)
  - Meeting Room Dahlia (20 – 25 people)
  - Director's Meeting Room (10 – 15 people)
  - Information Technology Unit allocated

    - IT Training Room Semarak
    - IT Training Room Kekwa
    - IT Meeting Room
    - Each departments & units shall allocated Seminar/Meeting Rooms

4.2 Finance

4.2.1 Allocation and Expenditure

i. Hospital fund shall be allocated according to Activity by department/unit.

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

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

iv. The Finance Committee *(Jawatankuasa Pengurusan Kewangan dan Akaun-JPKA) and (Jawatankuasa Pengurusan Aset Kerajaan- JKPAK)* shall be established to discuss financial and account issues including expenditure status, budget reallocation and additional requirement. The Hospital Director shall be fully responsible for the management of allocation and expenditure of the hospital.

v. The Hospital Director will request for the hospital budget allocation according to each departments and units necessity annually.

4.2.2 Procurement

i. Procurement of hospital supplies or specific items shall be coordinated by the Developmental Unit and relevant department.

ii. The procurement process include activation of 3 various committees i.e. Specification, Technical and Financial. The Hospital Management Committee shall establish a system that is transparent to ensure that the procurement process is carried out in accordance to Treasury Instructions.

4.2.3 Claims and loans

i. Staff shall be required to submit claims within the first ten days of the following month. It shall be completed, signed and attached with the necessary documents. Claims on overtime shall be followed in accordance with treasury guidelines.

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

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

4.3 Revenue Collection (Hospital Revenue)

4.3.1 Hospital Charges

i. Fees shall be charged in accordance to the Fee Order (Medical) 1982, Fee Order (Medical) (Amendment) (Foreigner) 2003, Fee Order (Medical) (Full Paying Patient) 2007, Fee Act 1951 and the latest MOH Finance Circulars. Procedures not listed in the Fee Order shall be forwarded to the Finance Division for approval of fee. The hospital shall make available the information on hospitals fees/charges to all parties.

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

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

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

4.3.2 Billing & Payment

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

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

iii. The Malaysian Digital Economy Blueprint 2021 has stipulated that all agencies at the federal and state levels must use cashless payments as a more effective transaction method by the year 2022. In addition, the KKM Anti-Corruption Plan 2021-2022 has also outlined a cashless payment initiative cash at the health facility of the Ministry of Health to avoid leakage of Government revenue. Therefore, KKM including this hospital has implemented cashless payments from 1 October 2022. However, cash payments are still accepted if customers do not have an ATM/debit card or credit card or e-wallet.

iv. The hospital also accepts money order, postal order, bank draft and bankers’ cheques. Personal cheques are not accepted. Receipts shall be issued upon payment.

v. Hospital bed for patient shall be allocated according to class of entitlement and billed accordingly.

vi. Revenue collection shall be carried out by authorized personnel at a designated revenue counter identify by the hospital administration it shall be open 24 hours. The hospital bill shall be itemized in accordance to fee act.

vii. Patient’s cash and property shall be allocated to *Unit Hasil* during office hours, while after office hours, Saturdays, Sundays and Public Holidays shall be allocated to *Bilik Daftar Masuk* (BDM) in Emergency Department.

4.4 Human resource

4.4.1 Human Resource Planning

The hospital management shall ensure there are systems and procedures available to provide appropriate numbers of people with required skills are available in the hospital. The hospital management is responsible for human resource training in accordance to service needs and expansion plan. The Training Need Analysis (TNA) for all staff shall be developed to ensure the right staff undergoes the right training and it should be monitored by the Training Unit.

4.4.1.1 Orientation

i. Newly appointed Staff shall be informed about the terms and conditions of appointment as in the General Order and PKPA.

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

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

iv. Hands-on on ICT skills shall be arranged for all the new staffs in the hospital.

4.4.1.2 Placement

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

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

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

4.4.1.3 Work Attendance and Leave

i. Staff shall record their daily attendance and movement within working hours (using the appropriate person attendance system e.g. punch card, record book, access card, thumb print scanner service etc).

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

iii. Staff shall use HRMIS system for leave application. They shall make sure the leave has been approved before taking the leave.

iv. Staff shall inform their department/unit head immediately if they are not well to be present at work (EL) and shall submit the leave request form within (3) three working days / once back to work.

v. Staff shall inform their department/unit head immediately if they have been given Medical Certificates and shall submit the medical certificate (MC) within (3) three working days/ once back to work.

vi. Staff requesting for time-off during office hours shall complete the form (*Borang Permohonan Cuti Rehat*) based on how many hours.

vii. Staff requesting to leave the office during their working hours for personal matter must refer to '*Kebenaran Untuk Meninggalkan Pejabat Dalam Waktu Bekerja Di bawah Perintah Am 5 Bab G: Borang Permohonan Kebenaran Meninggalkan Pejabat Dalam Waktu Bekerja'* – recommended to replace (1) one day leave if hours taken exceeded (4) four hours.

viii. Staff requesting to leave the office during their working hours for official matters – no replacement of hours/leave needed

4.4.2 Professional Development

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

ii. Staff shall be required to attend CME/CPD/training programmes session for at least 7 days in a year proportionately.

iii. The log book/online CPD (MyCPD) should be updated every (3) three monthly.

iv. The hospital management (training unit) shall facilitate CME/CPD activities with each department/unit.

4.4.2.1 Performance evaluation

i. Every staff shall have My Portfolio which contain the job description, responsibilities and work procedures.

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

iii. Department/unit shall have its own system to monitor and evaluate staff technical competencies.

iv. Performance evaluation shall be carried out annually and at appropriate intervals using the standard format.

4.4.3 Ethics & Discipline

4.4.3.1 Dress Code & Work Behavior

i. Staff shall wear their respective uniform or proper working attire when they are at work. Batik attire is encouraged on Thursdays.

ii. Name tags and hospital identification card shall be worn at all time as part of the uniform/working attire.

iii. During working hours, staff shall render services in a professional manner so as to uphold the image of the hospital.

iv. The values of the MOH Corporate Culture i.e. caring, teamwork and professionalism shall be internalized and uphold by all staff while performing their duties.

4.4.3.2 Disciplinary Problem

Monitoring of staff performance shall be continuous. Staff with disciplinary problems shall be given counseling before being referred for disciplinary action. For disciplinary action please refer to General Orders (*Perintah Am Bab D Tatatertib*).

4.4.4 Staff Welfare & Safety

4.4.4.1 Staff Welfare

i. The hospital establishes *Kelab Kebajikan dan Sukan Jabatan Kesihatan Daerah Temerloh (KESUKES)* to provide opportunity for staff to get together, participate in sports or carry out other recreational activities and staff welfare.

ii. Hospital established Wellness Clinic (*Klinik Sejahtera*) for staff and IMMEDIATE family members with mild illness which open during office hours with the use of guarantee letter.

iii. Ex-Gratia Work Disaster Scheme is a scheme which provides compensation to hospital staff stricken by disasters while carrying out work that cause permanent disability or death, including those victimized because of retaliation as a result of action taken in the course of official duties Work Disaster is a disaster suffered by an official duties or an accident while performing official duties or an occupational disease. An officer is covered within the following period of time:

- While traveling to and from home to workplace
- While traveling to and from the workplace to the residence at an approved meal time and at all times while on official duty

4.4.4.2 Safety

i. Occupational Safety and Health Act (OSHA) Committee must be established in hospitals to facilitate safety regulations and minimize risk to staff, visitors and contractors.

ii. Hospital management shall provide a conducive hospital and office environment for the staff to achieve organizational goal.

iii. Staff must at all time adhere to universal precaution and all guidelines regarding infection control.

iv. Hospital management must provide safe working environment to protect staff, patients, visitors and contractors from possible harm and injury e.g: fall, needle prick injury and fire.

4.5 Hospital Safety and Security

4.5.1 Hospital Safety

4.5.1.1 Disaster Preparedness

i. An organizational structure shall be established for disaster management.

ii. The hospital shall develop disaster preparedness plans and policies for events such as fire, flood, tremors, earthquake, bomb threats, chemical threats, biological threat, mass casualty and others.

iii. Disaster preparedness plans shall be communicated to all staff.

iv. Staff shall be trained on use of special equipment, patient transportation and evacuation etc.

v. Drill / mock trial should be carried out yearly and evaluated.

4.5.1.2 Fire Safety

i. The Hospital shall appoint a fire safety officer also in the Disaster Committee and prepare a fire contingency plan.

ii. Appropriate fire equipment shall be made available in all areas and regularly maintained by checking the expiry date.

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

iv. Fire retardant doors shall 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 in accordance to 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 use of firefighting equipment. Fire drill shall be conducted regularly, at least once a year.

4.5.1.3 Radiation Protection

i. The hospital shall establish a Radiation Protection Committee and appoint a Radiation Protection Officer to oversee and coordinate activities related to radiation protection.

ii. Policies and procedures pertaining to radiation safety and protection shall be made available to all the relevant department and units. Briefing on the policies and procedures on radiation safety and protection shall be conducted for specific staff.

iii. Request for radiological imaging shall be done by a medical practitioner. The requesting doctor shall be responsible to screen patient for risk factors prior to the examination.

iv. Facilities or rooms where x-ray examinations are carried out shall have the necessary safety features such as lead lined screen, walls or doors.

v. Staff in the Imaging Department and in other department who handling the ionizing radiation machines shall be briefed on the policies and procedures on radiation safety and protection.

vi. Staff shall adhere to the regulation and guideline regarding the use, storage and disposal of ionizing radiation and the guideline on diagnostic imaging for pregnant women and women of childbearing age.

vii. Only qualified and trained personnel shall be allowed to operate the x-ray equipment. The radiographer and the assisting person involved shall wear the necessary attire for protection such as lead gown, thyroid shield etc.

viii. Staff working in x-ray controlled areas shall have radiation dose monitoring done. Outside the main imaging department, the radiation dose monitoring shall be carried out using pen dosimeter.

ix. Staff exposed to radiation shall have their blood count checked regularly and undergo necessary medical examination (SINARAN Screening).

4.5.1.4 Infection Control

i. The Infection Control & Antibiotic Usage Committee shall be established to monitor, advice, plan, supervise and coordinate all activities related to infection control. Issues pertaining to hospital infection shall be presented to the Committee for acknowledgement and further action.

ii. An infection control coordinator shall be appointed. The coordinator together with the liaison officer (link nurse/staff) from each department/unit/ward shall form the infection control team.

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

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

v. Medical personnel shall wash their hands or use the hygienic hand rub solution provided before and after examining patient at the wash sinks available in all patient care areas.

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

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

viii. 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 in the privatization contract.

ix. PPE (Personal Protective Equipment) shall be used by staff and patient when indicated.

x. Formulate and review policies and procedures regarding hospital acquired infection and proper usage of antimicrobial therapy.

xi. Disseminate knowledge, improve skills and inoculate desired values in health care workers about the subject through education and training.

xii. Disseminate and ensure compliance with the policies and procedures among health care workers (where applicable patients, relatives and visitors).

xiii. Plan out hospital wide infection control programme and activities yearly. This function is incorporated in the day to day activities of personnel, patients and visitors.

4.5.2 General Security

i. The different areas in the hospital shall be identified either as high, medium and low security. Examples of high security areas are the entrances, stores, revenue unit, wards, delivery suites and the Central Sterile Supply Unit.

ii. Areas identified as high or medium security shall have security measures installed and security guards placed full time. Other areas shall have a regular site patrol by the security guards which is under the supervision of Security Unit.

iii. Clear 'no entry' signs shall be placed in areas and on doors to the rooms, which are restricted for staff or authorized personnel only.

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

4.6 Public Relations and Media Management (Public Relations)

4.6.1 Information Counter

i. An information counter shall be made available during office hours to provide information assistances and directions to patient and public.

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

4.6.2 Complaints and Feedbacks

i. Common source of complaints are:
   - Verbal Complaints consists of complaints received in person through 3rd party and via telephone communication.
   - Written Complaints are complaints received through letters, faxes, emails, feedback forms from suggestion box and others. (Biro Pengaduan Awam).
   - Mass Media are complaints received through newspaper, radio, television and social website.

ii. These complaints can be categorized into mild, moderate and severe including medico-legal issues and shall be managed according to urgency irrespective by the source of complaint.

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

iv. For mild cases, feedback should be submitted within 5 days, moderate cases 15 days and severe cases 16 to 365 days.

v. For medico legal cases, Internal Inquiry should be conduct within 30 days. The report shall be submitted to The State Health Director within seven working days.

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

vii. The subsequent management of complaints shall be carried out in accordance with Guidelines on management of complaints and medico legal cases, Medical Practice Division Ministry of Health Malaysia March 2007.

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

4.6.3 Suggestion Box

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

ii. The suggestion boxes are placed in Hospital Entrance Lobby, Emergency & Trauma Department Lobby, Diagnostic Imaging Department Lobby, Labour Room Lobby, Specialist Clinic Lobby, Pharmacy Lobby, Record Office Lobby.

iii. The General Administration Unit shall be responsible for monitoring of comments or complaints received through the suggestion box and complaints in the newspaper.

iv. Complaints in the newspapers shall be notified to the Hospital Director and the relevant department/unit, as soon as possible.

4.6.4 Release of information

i. The hospital shall not make any statement on policy matters and on issues of public interest to the public or media.

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

4.6.5 Photography/Filming/Interview

i. The media shall be allowed to interview or take the patient's photograph only on consent of the patient and/or the relative and the hospital director.

ii. Commercial filming or drama shooting in the hospital compound is not encouraged. However, hospital director may give permission subject to the Ministry of Health regulation. Exemption may be given for MOH health promotion documentaries.

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

vii. Visitors not allowed for any photography/videography in the hospital premises especially in the clinical areas (updated signage published and attached on each departments/units entrance).

4.6.6 Public Forums and Exhibition

i. Hospital departments/units shall plan and organize talks/lectures or exhibition to provide health education to the public.

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

4.7 Board of Visitors

4.7.1 Hospital Board of Visitors

i. The hospital shall establish a Board of Visitors as required by the Ministry of Health. The Board members shall be appointed by the Ministry of Health 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 organizational 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/units and other public areas during working 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 CME session.

4.7.2 Board of Visitors for Psychiatric Hospitals

i. All hospitals gazetted as psychiatric hospitals shall appoint a Board of Visitors as required under Mental Health Act 2001.

ii. The appointment of a Board of Visitors for Psychiatric Hospitals by the Minister of Health shall consist of not more than 25 members depending on the number of hospital beds and number of admissions.

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

4.7.3 Hospital Volunteers

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

ii. A medical social work officer or any officers from the hospital may be appointed as coordinator. This person will be in charge in guiding the volunteers for their job scope and monitoring their services.

iii. This hospital volunteers shall abide to the hospital rules and regulations and shall render services in a professional manners.

4.8 Transport System

4.8.1 General Transport System and Ambulances

i. The ambulances shall be under the responsibility of the Emergency Department whilst the other vehicles will be by the Administration Unit. The number and type of vehicles supplied shall conform to the norms of the Ministry of Health.

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

iii. The hospital allocated 11 ambulances with 38 drivers divided into clinical and non clinical services whose working based on shift system:
- 1 saloon cars
- 2 vans
- 1 cargo van
- MPV
- 1 SUV
- 1 lorry
- 2 hearses each for Muslim and non Muslim

iv. Family members/relatives are not encouraged to accompany patients in the ambulance and are required to sign an indemnity form if they do only if requested for critical cases, however parents shall accompany pediatrics patients.

v. Family members/relatives not allowed to accompany Dangerous Illness List/Dead in Line (DIL issued) patients in the ambulance.

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

- Lorry shall be used to transport bulk items such as furniture and equipment
- The occupancy of the vehicle shall be in accordance with the manual of each type of vehicle
- The usage of the appropriate transport during emergency it is under the discretion of the Hospital Director
- The log book of all vehicles and ambulance shall be updated regularly each time being used
- Drivers shall ensure regular cleaning of the vehicles and ambulance
- Hospital vehicles shall be driven by hospital drivers with valid driving license and shall abide to the road traffic rules and regulation at all time

4.9 Visiting Hours

4.9.1 General

i. Visiting hour shall be determined by the hospital management depending on current health situation. Generally the visiting hours shall be as follows:

Weekdays, Saturday, Sunday and Public Holidays

12.30 pm - 2.00 pm

4.30 pm - 7.00 pm

ii. During visiting hours, relatives/visitors shall be allowed to visit patients in the general wards/units depending on critical and non critical areas.

iii. The number of relatives/visitors at one time depending on critical and non critical areas are unlimited under surveillances of security guards in each places.

iv. A special pass/card will be issued when necessary for the stable patients to go out temporarily from the wards/units during admission in the hospital with the tag on and shall be monitored by the staff in charge in the wards/units to be returned.

4.9.2 Outside Visiting Hours

i. Permission to visit the patient after visiting hours will be allowed by security personnel at the hospital entrance/staff in charge of the ward/unit with issuing special pass/card.

ii. Permission restricted for children age below 12 and must be accompanied by relatives especially for non critical areas.

iii. The number of relatives/visitors shall be restricted after visiting hours and only 2 visitors per patient at a time. The number of relatives/visitors includes children aged below 12 at one time depending on critical and non critical areas are unlimited under surveillances of security guards in each places.

iv. After visiting hours a visit shall not exceed more than half an hour. All visits after visiting hours shall be recorded in the book available.

v. A relative/next of kin shall be allowed to accompany patient subject to the approval of the ward staff. A special pass (waiting pass) shall be issued to one person in the following situation:

- Relatives to accompany critically ill and bed ridden patients. Only female relative shall be allowed to accompany patient in the female ward/cubicle
- Mothers or guardians to accompany children in the pediatric wards

- Mothers of babies admitted to the special care nursery for breastfeeding

4.9.3 Other Hospital Visitors

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

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

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

4.10 Traffic Control

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

ii. Drop-off and pick-up zone shall be provided near the entrance to the Specialist Clinic/ED/PAC-Labor Room for patients’ convenience.

iii. Parking outside the designated parking areas shall be strictly prohibited and monitored by security personals.

5. CLINICAL GOVERNANCE

Clinical governance is the term used to describe a systematic approach to maintaining and improving the quality of patient care within a health system. It was originally elaborated within the United Kingdom National Health Service (NHS), and its most widely cited formal definition describes it as "A framework through which NHS organizations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish".

In the local context, the objective of the Clinical Governance framework as stated in the "Framework Document and Companion Guide for The Integrated Management of Quality, Safety and Risk in the Malaysian Health Care System" are:

- To ensure that there is a systematic framework for the health care sector for the integration of quality, safety and risk management programs to support and drive the provision of safe, effective and high quality services.

- To drive core programs for quality, safety and risk management.

- To ensure that appropriate accountability, leadership and oversight arrangements are in place to institutionalize and internalize quality and safety.

This section will focus on policies directly related to patient and patient care. Refer to "Achieving Excellence in Clinical Governance" by the Patient Safety Council of Malaysia & Quality in Medical Care Section, Medical Development Division, and Ministry of Health.

PATIENT RELATED POLICIES

5.1 Patients and Families' Rights

It is the rights to which patients and families are entitled as recipients of medical care. Typically, a statement articulates the positive rights which doctors and hospitals ought to provide patients, thereby providing information, offering fair treatment, and granting them autonomy over medical decisions;

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

ii. No patient shall be discriminated based on his/her race, gender, sex, religious belief, social and economic status or on any other factors.

iii. The hospital shall be responsible for the safety of the patient during his/her stay in the hospital.

iv. Treatment shall be given based on patient's clinical condition. Treatments provided to patients are individualized in respect to the disease and given in a quality and safe manner. Administration of pain management shall be given where appropriate.

v. The hospital shall communicate with the patient and family on the disease condition, the treatment options available, investigations, diagnosis and prognosis. Patient and family shall involve in making informed decisions concerning care including the right to refuse proposed treatment, experimental care, participating in research projects and right to leave the Hospital against medical advice. Any decision made by the patient and family shall be respected.

vi. All patients shall be given appropriate counseling prior to being granted discharge from the hospital against medical advice.

vii. All patients shall have access to information on all services provided by the hospital including to an Interpreter if language barrier exists.

viii. All patients shall get information on identity of the medical practitioners and other care givers.

ix. All patients shall have access to information regarding itemized statement of all charges and financial assistance that may be available.

x. All patients shall have access to information on applicable and relevant hospital rules and policies, health promotion, quality and performance improvement in the Hospital and relevant information on the procurement, donation process and transplantation process where necessary.

xi. The use of short form in the documentation shall be according to guidelines and circular by MOH.

5.2 Consent

Informed consent in ethics usually refers to the idea that a person must be fully informed about 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;

i. As a general guide, the following type of procedure shall require a signed consent form:
   - surgical procedure
   - general anesthesia
   - regional anesthesia
   - invasive radiology procedure
   - blood transfusion
   - other high risk and or invasive treatment

ii. All consent must be taken by a fully registered doctor using the appropriate forms. The information provided includes:
   - patient’s condition
   - proposed treatment
   - potential benefits and risks
   - possible alternatives
   - likelihood of success
   - possible problems related to recovery
   - possible results of non treatment

iii. Consent should be taken prior to carrying out any clinical procedures or treatments. In instances where consent is required it must first be obtained from:

a. The patient if he/she is of ages (18 years old and above) and of sound mind, OR

b. If the patient is incapable of giving consent, in the case of a minor or does not have the mental capacity to make a sound decision, consent should be taken from patient's guardian / relative as defined in the Mental Health Act;

"Relative" means any of the following persons of or above eighteen years of age:

(i) husband or wife;
(j) son or daughter;
(k) father or mother;
(l) brother or sister;
(m) grandparent;
(n) grandchild;
(o) maternal or paternal uncle or aunt;
(p) nephew or niece.

"Guardian", in relation to a minor, means the parent or parents of the minor, or a person lawfully appointed by will or by an order of a competent Court to be the guardian of the minor, or a person who has lawful custody of the minor.

iv. For emergency cases where the family members are not contactable, consent can be given by (2) two specialist from the related specialty.

v. The use of photographic, audio and video in patient care must be with prior approval from Hospital Director.

vi. Photographic, audio and video recordings which are made for treating or assessing a patient must not be used for any purpose other than the patient's care or the audit of that care, with the written consent of the patient or a person with parental responsibility for the patient. If you wish to use such a recording for education, publication or research purposes, you must seek consent in writing, ensuring that the person giving consent is fully aware of the possible uses of the material. In particular, the person must be made aware that you may not be able to control future use of the material once it has been placed in the public domain.

5.3 Counter Services

i. Hospitals shall have General Information counter and dedicated counters e.g. registration counters, clinic counters, ward counters etc. whose function include:

- Providing information
- Providing assistance
- Receive complaint etc

ii. The counter shall be manned by competent persons with good Public Relations skill.

iii. Public Relation Officer shall supervise the effective delivery of counter.

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

v. The Specialist Clinic Registration Counter also creates a R-Lane for the Senior Citizen, Children, Expectant Mothers, Disabled Persons (Orang Kelainan Upaya – OKU), Psychiatric Patients, Bedridden Patients, Special Children and others.

5.4 Appointment and Scheduling

i. Appointment may be made by phone, or coming personally to the clinic.

ii. Services shall be given on an appointment basis except for Emergencies Department.

iii. Rescheduling for early appointment, shall be upon approval by the relevant Head of Department / Units.

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

v. Walk in patient shall be seen on the same day if necessary or given nearest available date.

5.5 Registration

i. Patients shall be given only one medical record number (MRN) for personal identification. The MRN shall be used in all forms/ documents pertaining to patient care.

ii. Registration format shall be as specified by the Ministry or the hospital. The staff at the registration counter shall be responsible for ensuring the completeness of the information.

iii. All clients requiring registration must present relevant documents at the designated registration counters (available in the IT system).

Warganegara : Kad Pengenalan (baru/ lama)
Warganegara : Kad Pengenalan (ibu/ bapa) untuk kanak-kanak Warganegara : Sijil kelahiran/ Sijil Beranak untuk kanak-kanak Warganegara : Kad Pengenalan kanak-kanak (Mykid) Warganegara : Kad Identiti (pegawai polis/ tentera)
Bukan Warganegara : Passport Antarabangsa
Bukan Warganegara : Kad Permit Kerja

iv. Unknown patient shall be temporarily registered using designated running number. Registration process shall be updated, within 24 hours. If information of unknown patient is not available after 24 hours, a police report shall be made (refer *Pekeliling Makluman Kewajiban Proses Pendaftaran*).

5.6 Consultation

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

ii. The assessment of patients shall be documented in the designated clerking forms (manual/I.T.) comprising a full medical history and physical examination.

iii. The hospital shall ensure safety, confidentiality and privacy of the client throughout consultation and 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. In-patients shall be reviewed at least once a day by a medical officer/specialist and when necessary according to the patient's clinical condition.

vi. Examination of a female patient by a male doctor must be done in the presence of the chaperone, who is a medical personnel. This must be strictly observed for gynaecological and intimate examination.

5.7 Admission

5.7.1 Patient Admission Flow

i. Patient's admission formalities shall be carried out by the Admission Unit. All patients shall be admitted to the respective wards according to their eligibility.

ii. Stable patients from the referring hospital / health clinic can be admitted directly to the relevant ward after consultation with the ward doctor. All referrals for admission shall be in accordance with existing guidelines as stated in the *Pekeliling Ketua Pengarah Kesihatan* 11/2009; *Rujukan dan Perpindahan Pesakit Diantara Hospital-Hospital Kementerian Kesihatan.*

iii. All unstable patients shall be stabilized in the Emergency Department before admission to the ward. Direct admission to the Intensive Care for very ill patient shall be arranged with prior consultation and agreement by the Specialist in charge.

iv. All maternity cases (28 weeks and above) shall be sent directly at Patient Assessment Centre (PAC) and the necessary admission formalities attended to subsequently.

v. Patients or their relatives shall pay a deposit or produce a guarantee letter on admission in accordance with the Fees [Medical] Order 1982, Perintah Fi [Perubatan] Pindaan 2003 – Caj Baru Bagi Pesakit Orang Asing' and Garis Panduan Pelaksanaan Perintah Fi (Perubatan) (Kos Perkhidmatan) 2014.

vi. Patients shall be transported on mobile beds, transport trolleys (cot bed) or wheelchairs. Ambulant patients may be escorted by medical staff. Patients aged 12 years (who do not have Identification Card) and below shall be admitted to the Paediatrics Ward.

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

viii. Admission of patient to specific ward shall be withhold if/when the ward is temporarily gazette as infectious disease ward during outbreak of infectious disease and existing patient redirected to other ward.

5.7.2 Arrival at Ward

i. An identification wristband shall be provided to all inpatients. All inpatients shall be required to wear an identification wristband all the time during the hospital stay.

ii. Assignment of beds shall be done by the respective ward nurse. Patient of the same sex shall be admitted in same the room or cubicle.

iii. Placement in multiple bed wards may be possible for Nurse shall inform the doctors within 15 minutes for newly admitted patient.

iv. Individual patient shall be provided with a bed, chair and a locker if available. Facilities like toilet, bath and rest area shall be shared.

v. Patient shall be provided with the hospital clothes to wear.

vi. All patients who are admitted shall be given an orientation which includes information in relation to housekeeping, ward and hospital facilities by the ward staff.

vii. Patients are advised against wearing jewelry or bring along valuable items including large amount of cash for admission. They shall be informed that the hospital management shall not be responsible for any loss of valuable items (signage updated).

viii. The hospital management shall temporarily keep the patient's belongings or valuable in the Unit Hasil/BDM, when requested by patient. Patient shall be advised to immediately give it to the next-of-kin to bring home.

5.7.3 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 / Medical Registration Number – MRN given.

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

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

iv. For psychiatric patients;

a. Form 1 ‘*Volunteer Admission to Psychiatric Ward’* shall be fill up for volunteered patient.

b. Form 3 ‘*Involuntary Admission* to *Psychiatric Ward’* shall be fill up by family members for the involuntary psychiatric patients.

c. Form 4 *‘Recommendation of Admission for Involuntary Patient to Psychiatric Ward by a Medical Officer or Registered Medical Practitioner’* shall be fill up in accordance with Section 10(1)(b) Mental Health Act 2001.

d. Form 5 *‘Order of Admission into Psychiatric Hospital by Medical Officer or Registered Medical Practitioner or by Order of Court’* shall be fill up for the psychiatric patients brought in by police team in accordance with Section 14 Mental Health Act 2001.

5.7.4 Admission to First Class Ward

i. Patients shall be admitted to First Class ward when the necessary financial circulars have been complied with.

ii. Patients shall be admitted on a ‘first come first serve’ basis.

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

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

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

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

5.7.5 Dangerously Ill List Patient (DIL)

i. All patients in the hospital who have incurable and progressively fatal illness should have a care plan outlined by the specialist in charge. The patient's prognosis and issue of CPR (Cardiopulmonary Resuscitation), intubation, ICU admission in the event of rapid deterioration and cardio-respiratory collapse due to their illness should be discussed with patient and/or family and clearly documented in the patient's clinical note.

ii. Resuscitation status is a medical decision and should be made by the treating clinicians. Discussion regarding this should therefore not imply that the family is being asked to make such a decision but merely to inform and understand the rationale for such a decision is being made.

iii. The family and caretakers of all patients admitted should be made aware of the status of the patient's disease as well as intent of treatment. They should be aware that for DIL patient, resuscitation is often inappropriate and futile if deterioration is due to their primary disease.

5.8 Discharge

5.8.1 Planned Discharge

i. The Medical Officer / Specialist in charge of the patient shall be responsible for communicating information in relation to planned discharge not less than 24 hours in advance.

ii. Identification wristbands shall be removed at discharge except for newborn and paediatric.

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

iv. For patients of sound mind they are allowed to be discharge with any of their family members/next of kin. However, if patients is below 18 years old or of unsound mind, the family members/next of kin to whom the patients is to be discharged to, should be identified.

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

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

vii. For patient discharge the patient or family member shall be directed to the Revenue Unit or Admission Counter (A&E) to settle the bill and bring the document back to the ward.

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

ix. Citizens (Patient) who are unable to settle their bill due to financial reason will be referred to the Medical Social Department / Revenue Unit/ hospital administration.

5.8.2 <u>Discharged at Own Risk (AOR)</u>

i. All patients requesting to be discharged against medical advised can do so after obtaining adequate explanation and clarification and from the medical officer in charge.

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

5.8.3 <u>Absconded Patient</u>

i. Patient 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. If the patient remained missing after 24 hours, a police report shall be made.

5.9 Mortuary Services

5.9.1 Death in Hospital

i. All deaths shall be confirmed by the attending medical officer.

ii. On confirming death, the ward staffs shall verify the deceased status as organ donor; notify the mortuary and the next of kin.

iii. All deaths must be notified to mortuary, and high risk cases shall be made aware to the mortuary staffs.

iv. Management and handling of infectious dead bodies shall be in accordance to the standard precautions to prevent cross infection as per stipulated guidelines. The Health Inspector in the District Health Office shall be notified by ward staffs.

v. For Police cases, the Police must be notified of the death by ward staffs. Mortuary staffs shall be made aware of the same. Police cases are death involving Police investigation under Criminal Procedure Code (Act 593) while Non Police cases are cases with known cause of death and is not under Police investigation under the Criminal Procedure Code (Act 593).

vi. If there is no next of kin when the deceased was confirmed death, the ward staffs shall inform the next of kin by phone. If next of kin cannot be contacted, Police assistance shall be sought.

vii. Last office procedures and documentation shall be undertaken by the ward staffs, which include the removal of any tubing and medical devices. Nevertheless, the attending medical officer may, if he/she is of the opinion that such cases requires postmortem examination, he/she may leave all the medical devices in situ pending for forensic postmortem examination.

viii. Hospital tag/wrist band shall remain with the body, and all bodies shall be tagged with body identification tag. If Police cases, ward staff shall make a note on the body identification tag.

ix. The following documents/forms shall be filled up completely by the attending and fully registered medical officer:

   a. Borang Perakuan Pegawai Perubatan Mengenai Sebab-sebab Kematian (Akta Pendaftaran Kelahiran Dan Kematian, 1957 – (Seksyen 22(1); Kaedah 9) – JPN.LM09 in two copies.

   b. *Borang Daftar Kematian/Permit Mengubur (Akta Pendaftaran Kelahiran Dan Kematian, 1957 (Seksyen 4(1) Kaedah 5) – JPN.LM02 (Pin.1/11)* in four copies.

x. The forms cannot be discarded under any circumstances. If the forms are cancelled, damaged, etc, the forms shall be return to mortuary.

xi. Bodies shall be transferred to the mortuary by mortuary personnel accompanied by relevant forms mentioned above after one hour of being pronounced dead / confirmation of death.

xii. Bodies received at mortuary and the claimants are recorded in the Death Registration Book.

xiii. Bodies shall be stored at body freezers unless identified and claimed within 4 hours from the time of arrival at mortuary.

xiv. All relevant details pertaining to the deceased and claimants of the body are verified prior to release of body.

xv. All bodies (Non Police cases) shall be released to the next of kin within 3 hours from the time bodies are received in the mortuary.

xvi. For all bodies classified as Police cases, the Police shall be notified and clearance shall be obtained before release/disposal of the bodies.

xvii. For bodies of Foreigners, the related High Commission/ Embassy needs to be notified for issuance of confirmation on the status of nationality of the deceased prior to releasing the dead body to the claimants/appointed representatives.

xviii. The hospital does not provide any service or facility for the arrangement of last rites or funeral rites.

xix. The hospital provides transportation services subject to availability of vehicle, and charges will be incurred as per stipulated guidelines.

xx. The forensic staffs shall not be involved in the procedures of last rites including escorting the body during transportation.

xxi. Hospital shall not be held responsible for any untoward incidences once body has been claimed.

xxii. For unknown bodies;

a. The claimant shall be verified with the necessary and valid documents to proceed with visual identification of the body. A police report regarding the identification shall then be made. The deceased's name shall then be changed from John/Jane Doe in HIS system and burial permit, to the name as stated in those valid documents. Valid documents may include identification cards, passport etc.

b. If unclaimed, identifiers shall be collected and documented before releasing body as per stipulated guidelines for unclaimed bodies.

xxiii. For unclaimed bodies, Police shall be notified to locate the next of kin. If unsuccessful after various measures, the body shall be handed over to the respective religious body for burial after 3 days (Muslim) or up to 14 days (Non Muslim). Bodies may also be released to the universities based on the existing guidelines.

5.9.2 Management of Body Parts or Fetus (Less Than 500gram)

i. All body parts or fetus (less than 500gram) shall be released by ward staffs to the next of kin together with the completed *Permit Mengubur* (JPN.LM02), the "*Pemaklum*" and "*Penjaga Kubur*" copies (Yellow and Blue copies); while the "JPN" and "Hospital" copies (White and Pink copies), shall be returned to mortuary by ward staffs.

ii. If next of kin not available for release body parts/fetus, the ward staffs shall informed mortuary and send the body parts/fetus to the mortuary for temporary storage, together with completed *Permit Mengubur* (JPN.LM02), in all 4 copies. Ward staffs shall be responsible to inform the next of kin or patient to claim the body parts or fetus during discharged.

iii. The forms cannot be discarded under any circumstances. If the forms are cancelled, damaged, etc, the forms shall be return to mortuary.

5.9.3 <u>Death of Patient While In-Transit</u>

i. In the event of a death in transit, the ambulance should return to its base.

ii. In the absence of an accompanying doctor in the ambulance for confirmation of death, the vehicle should make for the nearest hospital to confirm death by a doctor and then return to its base after confirmation of death.

5.9.4 <u>Brought In Death (BID)</u>

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

ii. BID cases brought by family members/public shall be seen and registered at Emergency Department and a police report shall be made before transferring the body to mortuary.

iii. The police shall precede the investigation in accordance with the Criminal Procedure Code (Act 593).

iv. Cases which require Crime Scene Investigation (CSI) as requested by the police or cases which involved investigation under Penal Code (Act 574) will be under the responsibility of Forensic Medicine Specialist/Consultant on duty at Hospital Tengku Ampuan Afzan (HTAA), Kuantan.

v. Postmortem shall be performed by the Forensic Pathologist or Medical Officer from the Forensic Medicine Department (HTAA, Kuantan)/ Forensic Medicine Unit (HOSHAS, Temerloh) as according to the necessity of cases.

vi. The body can be released after all the relevant procedures are done and clearance has been obtained from the Police.

5.9.5 Postmortem Examination

i. For deaths in hospital that are Non-Police cases, if the cause of death could not be determined, a clinical postmortem examination maybe requested by the clinician. Consent from the next of kin must be obtained by the requesting team and must refer the case to the anatomical pathologist on duty. If the postmortem examination is not consented by the next of kin, the clinician may certify death with the closest diagnosis as the likely cause of death. If there is no clear working diagnosis, the cause of death may be written as “undetermined” or “unascertained”.

ii. For Police cases, the police shall decide the need for medico legal postmortem examination and issue a postmortem request.

iii. Medico legal postmortem examination shall be performed by the Forensic Pathologist or Medical Officer from the Forensic Medicine Department (HTAA, Kuantan)/ Forensic Medicine Unit (HOSHAS, Temerloh) as according to the necessity of cases.

5.10 Referral System

5.10.1 General

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

ii. Referral of patients between hospitals can occur from a lower to higher 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. There is pre-existing transfer arrangements between the facilities and pre-transfer communication between appropriate responsible persons to facilitate efficient flow of continuum of care to the patient.

iv. Existing guidelines such as "*Pekeliling KPK Bil. 2/2009: Garis Panduan Rujukan dan Perpindahan Pesakit di Antara Hospital-Hospital KKM*" shall be complied with when referring patient.

5.10.2 Intra Facility Transfer

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

ii. All patients requiring assisted ventilation from Emergency Department may be admitted directly to critical care ward after consultation between the specialist and anesthetist-in-charge of the critical care ward if bed(s) available.

5.10.3 Inter Facility Transfer

i. The decision to transfer a patient shall be made upon consultation with the specialist concerned.

ii. All patients shall be stabilized and deemed stable by medical officer in charge before transfer.

iii. Patient's next-of-kin shall be informed about the process of transfer. In the event where the transfer is urgent and patient's next-of-kin are not contactable, the police shall be informed to help in contacting them.

iv. The staff accompanying referred cases shall be decided by the specialist in charge. For hospitals without specialist this will be decided by the medical officer in charge after consultation with the receiving hospital.

v. All critical patients shall be accompanied by a team of paramedics trained in resuscitation and headed by a medical officer. Accompanying staff for other cases shall be decided by the specialist / medical officer in charge based upon the clinical condition of the patients.

vi. All documents pertaining to patient's condition shall be made available to facilitate the transfer. Referral letter accompanying patient should include a detail history of patient and reason for referral. All related radiological images & report, blood results should be included.

vii. Monitoring of patients shall be done base on the clinical condition of the patient and recorded accordingly.

viii. If patient's clinical condition deteriorates during the transfer and resuscitation is required, the ambulance may en route to the nearest health facility.

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

5.10.4 Interdepartmental Referral

i. Referral is divided into 2 types which are inpatient referral involving patients who have been enrolled in the ward and outpatient referral for patient from the Emergency Department or clinic.

ii. There are 2 reference categories which are urgent (needs immediate action to save lives / avoid long morbidity) and non urgent (no immediate action is required).

iii. Decisions for referral must be made from the medical officer level and above.

iv. Reference should have specific elements especially diagnosis, current treatment and purpose of reference (reference form in HIS).

v. For urgent cases, a specialist must refer to a specialist. A medical officer is allowed to refer if the specialist is performing an important task / procedure at that time. For non urgent case, Medical Officer must refer to either specialist / Medical Officer. This is to ensure that accurate information informed and reasonable reaction made immediately. In the case of an urgent case it is assumed that the relevant specialist will discuss and conduct the joint examination. This should be noted in the patient's notes.

vi. All references must be reviewed. The reference is considered to have been responded to only after the case has been reviewed by a Medical Officer or Specialist.

vii. In case of an urgent referral, the referral should be seen within 10 minutes whilst for non urgent case, reference should be seen within 6 hours.

5.11 Documentation of Clinical Care

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

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

iii. Documentation of clinical care shall be maintained by authorized hospital personnel attending to the patient and each entry shall be dated, initialed and stamped. (Not applicable for HIS)

iv. All amendments made must be clearly cancelled, initialed and stamped by the respective authorized hospital personnel. Entries shall not be deleted by corrective fluid (for manual record) whilst in HIS, correction must be made under addendum.

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

iv. Management of Patient Medical Record shall be in accordance to *Pekeliling Ketua Pengarah Kesihatan 17/2010*.

5.12 Procedure and Surgery

i. Each patient's procedure or surgery is planned and documented in the patient's case notes.

ii. The risks, benefits and alternatives are discussed with patient and family and should be documented in the patient's case notes.

iii. All consent must be taken by a medical officer using the appropriate form.

iv. Efforts shall be made to ensure that the procedure is carried out on:
   - The right patient
   - The right site
   - The right procedure

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

vi. The surgery performed is recorded using a pre prepared format and attached to the patient's case notes. Documentation should include the post operative diagnosis, a description of the surgical procedure, findings and any surgical specimen sent and the name of the surgeon and assistant.

vii. Each patient's hemodynamic status is continuously monitored during and immediately after surgery and written in the patient's case notes.

viii. Patient care after surgery is planned and documented.

5.13 Pain Free Program

5.13.1 Policy on Pain Assessment and Management

i. Pain shall be the fifth vital sign.

ii. Pain shall be assessed in all patients.

iii. Standardized pain assessment tools shall be applied consistently.

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

v. Healthcare personnel shall be given continuous education & awareness on pain assessment and management.

5.13.2 Client Charter

i. This hospital shall endeavour to provide patient with a pain free experience.

ii. This hospital shall treat pain from all conditions including pain from acute medical conditions, surgery, trauma, cancer and labour.

iii. Patient's pain shall be given prompt attention and managed within one hour.

iv. All patients with pain shall be assessed and treated by trained professionals; for those with acute pain conditions, aim to achieve a pain score of less than four (4).

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

vi. Health care professionals shall monitor patient's pain score and care for patient's comfort throughout the stay.

vii. HoSHAS shall endeavour to provide a pain free surgical experience.

5.13.3 Criteria for Pain Free Hospital

HoSHAS shall –

i. have a written policy on pain assessment and management.

ii. implement pain as the 5th vital sign.

iii. have standardized treatment protocols for management of acute pain.

iv. train all healthcare personnel on knowledge and skills in pain assessment and management.

v. educate patients and get them actively involved in their own pain management.

vi. carry out regular audit of pain assessment and management practices and outcomes.

vii. use multi-disciplinary team approach in pain management.

viii. incorporate non-pharmacological technique into pain management practices.

ix. have policy on minimally invasive surgery.

5.13.4 Minimally Invasive Surgery (MIS)

5.13.4.1 Promotion of MIS

HoSHAS shall undertake to encourage and promote MIS and shall –

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

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

iii. participate in all Ministry initiated programs that promote MIS.

5.13.4.2 Practice of MIS in Hospital

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

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

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

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

5.13.4.3 Encouraging Day Care Surgery

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

5.13.4.4 Credentialing and Privileging

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

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

5.13.4.5 Training in MIS

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

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

5.13.4.6 Equipment

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

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

5.13.4.7 Safety/ Audit/ QA

HoSHAS shall ensure that –

i. All safety aspects necessary for the performance of any MIS procedures are performed in a safe manner and in accordance with the strictest standards.

ii. Audit is conducted to monitor surgical complications and adverse events; and

iii. Quality Assurance Programs are in place to ensure favourable outcomes of MIS.

5.13.4.8 New or Experimental Procedures

i. All surgeons shall make necessary application for approval from the MOH and satisfy all criteria necessary to perform any new or experimental MIS procedure;

ii. HoSHAS shall ensure that all ethical issues and safety aspects relating to any patient shall be addressed and given the utmost importance.

5.14 Drug and Medication

5.14.1 Usage

i. Hospital drug formulary shall be maintained and used as a guide for drug prescription.

ii. Prescription and supply of drugs not listed in the Hospital drug formulary but available in the Ministry drug formulary (blue book) shall require the Drug and Therapeutic Committee's approval.

iii. Prescription and supply of drugs not listed in the Ministry drug formulary (blue book) shall require the Director General of Health /Senior Director of Pharmaceutical Services' approval. The respective head of the department shall be responsible for the justifications of the drug usage and cost implication.

iv. Request for approval shall be made using the specified format and Submitted through the director's office.

5.14.2 Prescription

i. Doctors shall prescribe drugs only to registered patients.

ii. Prescription referred by the pharmacy department from other Ministry of Health hospitals and clinics shall be accepted.

iii. Prescription from other Ministry of Health hospitals and clinics without referral by the pharmacy department and prescription from other government facilities shall be endorsed and re-prescribed by the hospital specialist in-charge before prescription is filled, subject to availability of drugs.

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

v. Term prescription (more than 1 month) shall be filled in at specified intervals. Patient shall be required to collect their medicines within one week of the date of prescription.

5.14.3 Dispensing

i. Drugs shall be dispensed at the specified pharmacy counter. Dispensing of drugs to patients shall be done according to the Pharmacy Department operation time.

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

iii. Bedside dispensing shall be carried out for discharged patients according to the inpatient operation time for bedside dispensing.

iv. Pharmacy value added services are provided optimize efficiency and enhance customer experience at the outpatient counter of the hospital.

5.14.4 Monitoring

i. Usage of drugs, prescriptions and drug reaction shall be monitored by the pharmacy department.

ii. Drug and Therapeutic Committee shall be established to coordinate, monitor and manage all issues relating to drugs and drug usage.

5.14.5 Sedation

i. Hospital shall provide safe procedure for all patient and done by trained personal.

5.15 Sterilization and Disinfection

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

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

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 are in good condition and develop plan for the restoration and replacement of non-functioning equipment.

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

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

viii. Clean, decontaminate and sterilize loaned instrumentation at the receiving facility. All consignment set should be delivered to the designated area (decontamination) in the CSSU.

ix. Obtain manufacturer's written IFU (Instruction For Use) before the loaned items are received. Vendor should provide manual instruction cleaning process and sterilization. Determine responsibility for ensuring the set weight no more than 25 pounds (11.3 kg).

5.16 Infection Control

The Hospital shall establish the Hospital Infection Control and Antibiotic Usage Committee who has an advisory, planning, coordinative and supervisory role which include mainly:

i. Formulation and review policies and procedures regarding hospital acquired infection and proper usage of antimicrobial therapy.

ii. Disseminate knowledge, improve skills and inculcate desired values in health care workers about the subject through education and training.

iii. Disseminate and ensure compliance with the policies and procedures among health care workers and (where applicable) patients, relatives and visitors.

iv. 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.

5.17 Management of Medical Records and Reports

5.17.1 Medical Records

i. Every patient receiving care in the hospital shall have his/her own medical record.

ii. Care given and procedures done on a patient shall 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.

iii. Hospital using the manual system (during HIS breakdown – BCP) shall implement an integrated case note where all care providers write their notes on the same continuing sheet and in chronological order. In HIS record are kept electronically.

iv. All case notes and treatment records of a patient shall be compiled as one medical record and kept in a single folder (only for hardcopy document).

v. Referral letter and other documents relating to the care shall be kept together with the patient's medical record.

vi. Management of medical records shall be under the responsibility of the Medical Record Department. The records shall be managed to ensure safety, confidentiality and fast retrieval.

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

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

ix. Existing guideline : *Garis Panduan Pengendalian dan Pengurusan Rekod Perubatan Pesakit Di Fasiliti KKM(2023)*" shall be complied in the management of patient medical record.

5.17.2 <u>Medical Report</u>

i. Medical report shall be prepared on receiving written request from the patient or authorized person.

ii. Medical report shall be prepared by a Medical Officer or Specialist in the respective discipline involved in the care. The report shall be prepared within a specified time i.e. 4 weeks for state/specialist (major) hospitals and 2 weeks for specialist (minor) and non-specialist hospitals as determined by the MOH.

iii. Medical report of medico-legal or potential medico-legal cases shall be prepared or verified by the head of the department and approved by the hospital director before release.

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

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

5.17.3 Medical Statistics

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

ii. The respective department and unit shall submit data to the Medical Record Department within the specified time.

iii. Release of medical data and statistics of the hospital shall be done through the Medical Record Department and subject to the Hospital Director's approval.

5.17.4 Medical Board

i. Existing guideline *'Pekeliling KPK Bil 13/2017 : "Garis Panduan Penubuhan Lembaga Perubatan di Fasiliti KKM"* shall be complied in the preparation of medical board report.

ii. All medical board application must be through State Health Office/Hospital Kuala Lumpur (HKL).

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

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

v. The Medical Board report must have 4 copies, 3 copies to be sent to State Health Office/HKL and one copy to be kept in the respective hospital. The report shall be ready within 60 working days from the application date.

5.18 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 shall plan, coordinate, implement, monitor and evaluate all activity related to health/patient education programs in line with current MOH policies.

iii. The Health Education Department / Unit shall organized training for staff on patient's education technique on the use of Health Education hardware and software.

5.19 Ethics and Law

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

5.20 Organ and Tissue Donation

5.20.1 The hospital management shall establish an organ procurement team and a mechanism to supports the choice of patients and families to donate organs and tissues for research/transplantation.

5.20.2 Designated staff is trained for the procurement, banking, and transportation or transplantation process.

5.20.3 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 religion (MOH – National Organ, Tissue and Cell Transplantation Policy, 2007).

5.21 Cluster Programme

5.21.1 Background of *Hospital Kluster Pahang Tengah* (HKPT)

Cluster Hospital (CH) is defined as grouping of hospitals by geographical locations within a state where the hospitals are aligned in terms of patient flow and services. The CH will share resources, facilities, manpower and equipment and shall be large enough to operate efficiently, provide a reasonable range of hospital services, safe and quality medical care.

Hospital Kluster Pahang Tengah (HKPT) began as a pilot project of CH since 2014. Currently, five (5) hospitals in HKPT are:

a) Hospital Sultan Haji Ahmad Shah (HoSHAS) as Lead Hospital (LH) - Since 2014.
b) Hospital Jengka as Non Lead Hospital (NLH) - Since 2014.
c) Hospital Jerantut as Non Lead Hospital (NLH) - Since 2014.
d) Hospital Bentong as Non Lead Hospital (NLH) - Since 2019.
e) Hospital Bera as Non Lead Hospital (NLH) - Since 2022.

5.21.2 Vision, Mission and Objective

VISION

An integrated network of hospitals working together continuously striving for improvement and excellence in the delivery of healthcare responding to the needs (and where possible, demands of the community).

MISSION

Bringing together a cluster of individual hospitals:

- Committed to implementing comprehensive and quality service delivery at affordable costs through integrated services based on the expectations and needs of the local community to improve access to more equitable treatment.
- Committed to the philosophy of organizational sharing through the establishment of corporate culture and organizational branding as well as the implementation of shared values that lead to success towards a common vision.
- Committed to implementing a fairer and equitable use of healthcare human resource in the cluster as well as the formation of a workforce that is trained, efficient, has integrity and is committed to implementing the organization's vision.
- The management and administration of cluster hospitals will also be focused on the needs of the local community and the achievement of common goals. At the same time, hospitals will implement services based on the needs of individual patients. Both are combined to improve the quality, equity and inclusiveness of the people in obtaining healthcare services.

OBJECTIVES

The objectives of HKPT are:

- To strengthen delivery of patient-centred services by redistribution of services and strengthening coordination of care by aligning patients and service flow with new workforce arrangements.
- To increase patients and staffs' satisfaction by increasing productivity and redistribution of workload.
- To improve level and quality of care by strengthening training and improving competency of staffs.
- To improve effectiveness and efficiency of service delivery by optimizing available resources through accountable sharing within the cluster and optimizing utilization of available resources, thus reducing wastage.
- To improve access to medical care and enhance equity by improving continuity of specialized care and by bringing services closer to home.
- To improve financial management of the hospitals and generating new resources to improve clinical care deliveries.
- To improve strategic communication & data sharing through enabling technology.

5.21.3 Organization and Governance of HKPT

5.21.3.1 Organization and Governance

i. Ministry of Health (MOH) and Pahang State Health Department (JKNP) shall monitor the implementation of the Cluster Hospital to be in compliance with existing rules and policies.

ii. Cluster Management Committee (CMC) shall be responsible and accountable for the provision of the day to day services in the cluster.

iii. Governing Body (GB) shall be responsible for the overall performance of the organization.

5.21.3.2 Cluster Hospital Committee

i. CMC shall identify the need for the establishment of certain committees to support and strengthen the implementation of the Cluster Hospital.

ii. If the committee is established, the CMC shall appoint the Chairman for the committee. The chairman shall appoint committee members comprising representatives from all hospitals within the cluster.

iii. Each committee shall be responsible for planning the implementation of each item based on cluster planning using analysed data and information involving all hospitals within the cluster. These Cluster Hospital committees shall plan, coordinate, implement, manage and monitor the performance of their respective committee activities and report to the CMC periodically.

5.21.3.3 Organization Chart

i. The organization structure shall be shared among hospitals within HKPT. Existing organization charts in each hospital shall be same.

ii. In the HKPT organization chart, the Integrated Services shall be seen as a combination of departments across all hospitals within the cluster.

iii. Other non-integrated services shall remain as they are in their respective hospitals.

5.21.4 Cluster Services

Cluster services are divided into two (2) types:

a) Integrated service

b) Coordinated service

5.21.4.1 Integrated Services

i. The integrated services shall act as ONE department and manage related issues including management and development of resources for example facilities, human resources and equipment.

ii. The training of officers, leave and Annual Performance Report (LNPT) shall be under the responsibility of the Head of Department at LH.

iii. Clinical, clinical support service or administration management to be integrated shall be determined by the CMC on the basis of service requirements, the capabilities of resources at all hospitals involved and the appropriate workload evaluation.

5.21.4.2 Coordinated Services

The coordinated services shall be operationalized by the respective hospital with collaboration between LH and NLH.

5.21.5 Services Available

5.21.5.1 Integrated Services

General Medicine
Emergency & Trauma
Pathology

5.21.5.2 Coordinated Services

General Surgery	Orthopaedic	Paediatric
Ophthalmology	Otorhinolaryngology	Obstetrics & Gynaecology
Psychiatry	CSSD	Pharmacy & Medical Store
Medical Social Work	Ambulance	Management - Training & Human Resource
Management - Finance	Management - Procurement	Management - Development
Management - Transport		

*Other non-cluster services available at each hospital shall be subjected to existing policy of individual hospitals.

5.21.6 Responsibilities

5.21.6.1 Lead Hospital Responsibilities

i. **Specialist Services**: Provide specialist medical services in various disciplines

ii. **Case Coordination**: Ensure that patients requiring specialized care are promptly referred to the Lead Hospital's specialists.

iii. **Training & Development**: Provide professional training to non-lead hospital staff to improve expertise in general and specialized healthcare management.

iv. **Service Oversight**: Supervise and ensure that all hospitals in the cluster adhere to established clinical and medical standards.

5.21.6.2 Non Lead Hospital Responsibilities

i. **Primary Care:** Provide primary healthcare services to patients, including general medical care, health monitoring, and emergency treatment.

ii. **Referral Coordination:** Non-lead hospitals must ensure that patients requiring specialized care are referred promptly to the Lead Hospital.

iii. **Data Collection:** Provide relevant patient data to be shared with the Lead Hospital through a secure communication system.

iv. **Support to Lead Hospital:** Provide ongoing care and support to patients after discharge from the Lead Hospital.

5.21.7 Monitoring and Evaluation

i. Periodic evaluations of the cluster model's effectiveness will be conducted by hospital management and relevant health bodies.

ii. Any issues in coordination or integration between hospitals will be addressed through discussion and improvement actions.

5.21.8 Conclusion

This policy emphasizes the importance of strong collaboration between hospitals in the cluster to ensure the delivery of quality and effective healthcare to the community. Continuous integration and coordination will strengthen the healthcare system in Malaysia, benefiting patients and ensuring better public health outcomes.

6. MEDICAL FACILITIES

6.1 Specialist Clinics

i. The clinics shall be used to provide specialist outpatient care. The consultation & examination rooms shall be commonly shared between the various department/unit as and when necessary. Patient's privacy must be maintained throughout the consultation.

ii. All specialist clinics shall be operated under the supervision of the specialist in-charge and shall remain operational during office hours based on a predetermine clinic schedule.

iii. All specialist clinic services are provided on an appointment basis which is based on an appointment and scheduling system determine by the respective hospital/department/unit (manual or computerized).

iv. All appointment is given based on the availability of resources. For urgent appointment, the referring doctor shall be required to consult the Specialist/medical officer of the respective discipline before referring the patient.

v. Rescheduling, cancellation and deferral of appointments shall be approved in accordance to the policy of the department / units approved by the hospital management.

vi. The necessary fees related to the services provided shall be paid by the client according to the Fees Medical Order Act 1982 / Revised Circulars and receipt issued.

vii. 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 and based on each clinic department policy. These must be monitored on a regular basis by the clinic for continuous improvement.

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

6.2 Emergency and Trauma Department

i. The hospital shall provide pre-hospital and hospital emergency services on 24-hours basis. The department shall be responsible for the emergency care to patients to save lives, preserve body functions and prevent complications. The services shall be under the responsibility of the Head of Emergency Department.

ii. A call center located in the emergency and trauma department shall be used to receive emergency calls from the public.

iii. The emergency department shall be used to provide emergency care to patients brought in or referred to the hospital.

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

v. During disaster, the department shall play a lead role in the management and treatment of the victims on site and in the hospital includes by providing a temporary shelter (includes for the hospital staffs who are affected).

vi. All patients shall be triaged according to zones/color; red for the critically ill, yellow for semi critical and green for non-critical patient.

vii. Critically ill patients shall be seen immediately by the attending doctors.

viii. Waiting time for the green zones shall be displayed at the Emergency Department.

ix. Stand by medical cover shall be coordinated and provided on request subject to the availability of staff and the policy and procedures of the ministry.

x. Locum services shall be provided upon approval of Ministry of Health.

6.3 Day Care

The day care unit shall be commonly shared/ utilized by all clinical disciplines for medical treatment, endoscope procedures and minor elective surgeries. Hospitals shall have a dynamic list of procedures performed as day care;

i. Daycare services shall be provided Monday to Friday (working days) from 7.00 am to 5.00pm.

ii. Patients selected to undergo day care procedure are low-risk patient. These patients for shall be admitted and discharged within the same day after the surgery or procedures.

iii. All patients scheduled for daycare services shall be furnished with all relevant documents to facilitate their registration and admission.

iv. Consent shall be obtained by the attending medical officer in charge for all daycare procedures after adequate explanation to the patient/relatives.

v. Patient shall be certified fit by a medical officer before discharge; if they are deemed unfit they shall be admitted to the respective wards for further management.

vi. Confirmation of patient undergoing daycare procedures must be made 24 to 48 hours prior to the procedure.

vii. Billing for these patients shall be in accordance with the Fees [Medical] Order 1982 and the Revised Circulars" *'No. [44 dlm. KKM 203/20 Jld. 6] Panduan Perlaksanaan Perintah Fi [Perubatan] Pindaan 2003 – Caj Baru Bagi Pesakit Orang Asing'* and official receipt issued.

6.4 Operation Theatre

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

ii. All elective surgeries shall be carried out on normal working days and hours according to schedule by respective department base on the allocated OT days. Additional elective OT may be carried out on weekend or public holidays in order to reduce waiting time depending on the need and availability of resources.

iii. Emergency OT shall be operational 24 hours a day; where applicable a second Emergency OT shall be open based on the necessity and availability of resources.

iv. All patients undergoing elective and emergency surgery shall be assessed by the anesthetic Medical Officer or Specialist.

v. All procedures carried out in the OT shall comply with all existing guidelines and policies (e.g. “Guidelines on Infection Control of Hospital Acquired Infections and the Disinfections and Sterilization Policy and Practice”, MOH, 2002).

6.5 Intensive Care (Critical Care)

i. Patients admitted to Intensive Care shall be cared for by the intensive care team from the department of anesthesiology along with the primary department / unit.

ii. The admission and discharge of all patients to and from ICU shall be determined by the Anesthesiologist-in-charge in consultation with the respective specialist from the referring department / unit.

iii. Priority for admission shall be based on the urgency of 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 anesthetist.

iv. When continuing intensive care is deemed medically futile (brain death), consideration shall be given to withholding or withdrawal of life support. This decision shall be discussed with the patient’s family and with other team members as appropriate. References to organs to procurement team shall be initiated.

v. In cases where relatives / next-of-kin requesting termination of treatment and AOR discharge for ill ventilated patients shall discuss with the specialist of the primary department / unit. Adequate explanation and the risks shall be given prior to approval for discharge and documented.

vi. Patients on AOR discharged shall be accompanied home by a nurse. Extubation of the patient shall be carried out by the nurse at home

vii. Relatives / next-of-kin requesting AOR discharge for ill ventilated patients to be transferred to other medical facilities shall discuss with the specialist of the primary department / unit. Adequate explanation and the risks and consequences involved shall be given prior to approval for AOR discharge. Pre-transfer communication between the specialists of the referring and receiving unit/facility shall be done.

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

ix. Purchasing of ICU services may be allowed when the ICU beds in the hospital and nearby government facilities are not available. Hospital Director, Head of the primary discipline and Head of Anesthesiology must be in agreement. Patient shall be recalled as soon as ICU bed is available within the hospital. Individual hospital shall pay for the service.

x. The clinical management of patients in intensive care unit shall be guided by management protocols in intensive care (MOH 2006) and other guidelines /protocol Occupational and Safety Health Assurance (OSHA).

xi. Specific infection control measures shall be adhered to (Guidelines on Infection Control of Hospital Acquired Infections and the Disinfections and Sterilization Policy and Practice", MOH, 2002).

xii. The Ideal Nursing Norm of nurse to patient ratio (1:1) according to the level of Intensive Care shall be adhered to during all shifts.

xiii. The number of intensive care unit beds shall be at least 3-5% of the total acute hospital beds in major hospitals. (Anesthesia & Intensive Care Services MOH/P/ 142.07 (BP), February 2008).

6.6 Laboratory and Blood Transfusion Services

Laboratory and blood transfusion services are delivered through the Pathology Department's laboratories, which operate 24 hours. Whereas for blood donation services are provided Monday to Friday (working days) from 8:00 am to 5:00 pm. These laboratories provide both basic and specialized services based on the hospital's administrative classification under the MOH. The services are structured and managed to ensure comprehensive, high-quality diagnostic support, prioritizing safe and effective patient care.

i. The Pathology Department is responsible for providing an up-to-date Laboratory User Manual, a Pathology Handbook, and a documented Standard Operating Procedures (Cross-Departmental Policies). These resources serve as guides for staff on specimen collection, handling, and transportation to the laboratory.

ii. Specimen collection shall follow the guidelines provided by the Pathology Department. The department is responsible to monitor the transportation condition of the samples to the laboratory to ensure quality of test results is maintained. The need for proof of delivery is under the responsibility of the clinical side.

iii. Tests shall only be requested by authorized personnel directly involved in patient management. Requests should be submitted using the designated laboratory form or electronically, where available, as per hospital protocols. Verbal requests for additional tests are strongly discouraged.

iv. A system must be established to ensure that all relevant tests are processed and validated by qualified (competent and authorized) personnel.

v. Automation shall be implemented to replace manual methods whenever applicable.

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

vii. The laboratory shall ensure that all equipment is properly maintained and suitable for use.

viii. Clinical interpretation of test results or reports must only be performed by clinically qualified personnel, such as trained Medical Officers or Pathologists. The laboratory is responsible for notifying the ward or clinic of test results that exceed "critical values" defined either nationally or through internal agreements. All urgent tests must receive immediate attention, with results communicated within the time frames set at the national or hospital level.

ix. The outsourcing of tests shall be conducted between government laboratories with a service agreement. Outsourcing tests to private labs should be coordinated by the requestor with accredited or technically competent private laboratories through the Pathology Department, as needed.

x. Point-of-care testing (POCT) that is technologically reliable may be permitted in critical care and other designated areas for tests essential to immediate patient management, subject to approval by the Hospital POCT Committee.

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

xii. Laboratory services shall be accredited by renowned International Accredited Body in order to fulfill clinical research requirement sponsorship.

7. QUALITY MANAGEMENT

7.1 Standard & Indicators

i. The national indicators, KPI, HPIA shall be used to monitor the hospital performance in quality care.

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

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

7.2 Quality Improvement Activities

i. The department and unit shall be responsible for the provision of quality service.

ii. The department and unit shall establish their own standards and indicators for monitoring quality.

iii. The hospital shall establish a Quality Management Committee to oversee and coordinate all activities on quality. Coordinators shall be appointed for the different activities.

v. The following quality activities shall be implemented:

- Quality assurance studies
- Quality Control Circle (KMK)
- Incident reporting
- Patient satisfaction survey
- Clients Charter
- ISO 9000 certification
- Hospital Accreditation certification
- Malaysian Patient Safety Goals
- Clinical Audition
- Mortality review (suspicious death, per operative and post operative death, maternal mortality, perinatal and neonatal mortality, specific communicable diseases death such as Dengue, Tuberculosis, Leptospirosis and others in accordance to Notifiable Disease Act)

All activities on quality improvement shall adhere to existing MOH guidelines and procedures. The departments and units in the hospital shall be responsible for the provision of quality and safe services. The departments and units in the hospital shall establish their own standards and indicators for monitoring quality.

8. TRAINING

8.1 Continuous Professional Development (CPD) Programme

i. Each hospital shall establish a structural organization to provide the direction and governance for the CPD programme.

ii. To maintain staff competency, which include technical, soft skill and communication skill, each personnel (both administrative and clinical) will be given the opportunity to attend training programmes in areas relevant to their functions.

iii. Sufficient funding and other resources which may include library, auditorium, seminar room, skill lab, computer lab etc. will be established in each hospital.

iv. Each hospital is encouraged to establish formal and informal linkages and collaborations with local and international health-related organizations to facilitate training activities.

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

8.2 Credentialing & Privileging

i. Each hospital shall establish a structural organization and mechanism for purposes of credentialing and/or privileging of clinical personnel relevant to type of services being offered. Refer to Guidelines: *Sistem* 'Credentialing' *dan* 'Privileging *di Kementerian Kesihatan Malaysia Bil 01/2001.*

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

8.3 House Officers and Other Post-Basic/Graduate Training

i. A hospital that has been designated as a training centre for undergraduates / House Officers and/or other post-basic/graduate programmes is required to establish a formalized training and assessment structure relevant to the type of training being provided.

ii. Each hospital with under graduate and post graduate activities shall establish an undergraduate and postgraduate committee to coordinate and monitor the activities.

9. RESEARCH

i. Each hospital is to establish a structural organization and mechanism to provide guidance and governance for research activities.

ii. Each hospital shall provide a conducive environment that will actively facilitate and support research activities. The hospital is encouraged to establish a clinical research centre / unit / facility to coordinate and provide technical support. Sufficient funding and other related resources shall be allocated.

iii. The hospital shall have a structure organization and activities to provide governance, guidance and support for research activities.

iv. Any research proposed to be undertaken within the hospital by hospital personnel or in collaboration with other agencies or by external agencies themselves (such as universities) must first seek the approval of the Hospital Director of Heath prior to submission to the Malaysian Research and Ethics Committee (MREC) of MOH.

v. All publications whether in the form of research reports, journal articles or conferences proceeding, arising of research undertaken by most personnel or conducted in MOH facilities or funded by MOH research grants, shall request prior review by the NIH and subsequent approval by the director general of health.

vi. All principle investigators and collaborators wishing to undertake interventional clinical trial research must acquire a Good Clinical Practice (GCP) certificate before being given permission to conduct trials.

vii. Consent to conduct research must be approved by Hospital Director and registered with MOH, all research involving human subject require prior ethic review and approval by the medical research and ethics committee (MREC) of MOH.

viii. The hospital shall tag and maintain medical records of the patients involved in clinical trials including all relevant research documents, management of records after expiry dates e.g. disposal / archiving shall be carried out in collaboration between the medical records unit and hospital CRC.

ix. All research shall adhere to current guideline for conducting research in Ministry of Health (MOH) institutions and facilities by National Institutes of Health (NIH).

10. SUPPLIES AND ASSETS

10.1 Procurement

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

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

iii. Procurement of office stationeries, food items, other non-medical items, IT consumables and medical equipment shall be coordinated by the procurement unit.

iv. The respective head of department and unit shall be responsible for preparing the technical specifications.

10.2 Equipment and Pharmaceutical Supplies

10.2.1 Requirement & Specification

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

ii. Requirement of medical equipment shall be decided by the individual department/unit and coordinated by the procurement unit.

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

10.2.2 Delivery & Supply

i. Standard items shall be stored for 4 months supply and non-standard item shall be made available only on request.

ii. Bulky equipment shall be delivered directly to the respective end user. An appointed end user shall be present to verify the delivery.

iii. All pharmaceutical supplies shall be delivered to the medical store. The supply of consumables shall be collected direct from medical store and the supply of drugs shall be collected from the ward supply pharmacy.

iv. An appointed end user shall be responsible to verify the contents, ensure compliance to the specifications and carry out testing and commissioning before signing the acceptance forms. Testing and commissioning process shall be carried out in the presence of appointed end user, supplier, Asset Manager and Radicare.

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

vi. Dangerous and Psychotropic Drugs shall be stored, transported, and managed only by authorized staff.

vii. Items requiring refrigeration (temperature 2-80C) and inflammable/ explosive materials shall be kept in individual storage area.

10.2.3 <u>Equipment / Inventory List and Loaning</u>

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

ii. Equipment shall not be moved or transferred to another department or another hospital without prior approval of the Hospital Director. Any movement of equipment shall be comply with the guidelines on asset management and documented.

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

iv. Equipment may be loaned within the hospital with approval of hospital director. There is no charge for loaned equipment.

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

vi. Supplies may be loaned to another hospital but must be replaced with and 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.

10.2.4 Disposal of Equipment

i. Head of department/unit shall be responsible to submit a list of equipment to be disposed/ condemned to the Asset Unit.

ii. Equipment which has been given the certificate of 'beyond economic repair' may be disposed accordingly.

iii. The respective head of department/unit shall be responsible for the safety of the equipment before disposal.

11. COMMUNICATION SYSTEM

11.1 Telephones

i. ‘A’ line shall be made available to the Hospital Director as head of organization.

ii. Heads of Clinical Departments may be provided with a type ‘B’ PABX line. Specific areas shall also be provided a type ‘B’ line. All other telephone lines within the hospital shall be of type ‘C’.

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

iv. Hand phones maybe provided to certain category of staff as follows:
- Hospital Director
- Heads of disciplines
- Designated personnel on active calls
- 999 personnel on active duties
- medical team/medical response team on duty

*In compliance with the government directives

v. Mobile phones should not be used in critical areas such as Red Zones, ICU and NICU in accordance to MOH guidelines.

vi. A two-way radio communication system shall be used between the ambulance and the station in response to an emergency call.

11.2 Nurse Call System

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

ii. Nurses shall attend to the patient immediately when the nurse call system is activated.

11.3 Public Address System

i. The Public Address (PA) system may be used for making announcements, alert and providing information.

ii. The PA system may also be used for emergency situations using specific codes as follows: (available in system)

- Red alert
- Pink alert
- Black alert
- White alert
- Code Orange
- Code Blue
- Code Grey

12. HOSPITAL AMENITIES

12.1 Car Park

i. Car park shall be made available for staff and public. Only cars with hospital stickers shall be allowed to enter the staff parking area. A few designated car parks for doctor on-call and disabled patients shall be made available with easy access to clinical areas.

ii. The Hospital shall not be responsible for the safety of the vehicles. Signage shall be put up to inform the public that vehicles are parked at their own risk.

12.2 Staff Facilities

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

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

iii. Call rooms and on call complex shall be provided for Doctors on-call.

vii. Accommodations or quarters shall be provided to some staff based on service needs, availability and eligibility.

viii. Sport complex (where applicable) shall be provided for recreational purpose to staff.

12.3 Public Facilities

i. Public facilities shall be under the responsibility of the General Administration Unit. The following are some of the facilities available for public use:

- Prayer rooms/*Pusat Islam* (PI)
- Breast feeding room
- Cafeteria
- Wash room and toilet
- Auto-teller machines/banking facilities
- Pondok rehat
- Playground

ii. Prayer rooms/*Pusat Islam* shall be opened for 24 hours to the public and staff.

13. PRIVATIZED SERVICES

13.1 Security Services

i. The security service in hospitals is privatized. Scope of service shall be based on the agreed contract.

ii. This service shall be operated by an appointed licensed security agency and shall be managed/ coordinated by the hospital General Administration Unit.

iii. To ensure the safety of government and public properties, the security services in the hospital shall encompasses the scope set below;

- Control the movement of patients, clients and staff in the hospital area where only authorize person are allowed.
- Ensure safety of hospital asset and properties.
- Ensuring smooth movement of vehicle traffic in accordance to traffic law.
- Ensuring physical safety of staff, patient and clients including appropriate response in the event of risk / hazard / disaster.

iv. The security plan shall include standard operation procedure including schedule patrol, outlet check, visitors check, staff check and 24 hour security location. The 24 hour security presence shall be determine by hospital but generally covers these minimum areas stated below:

- Emergency department
- Main entrance
- Labor room
- Maternity ward
- Pediatric ward including Neonatal unit
- High dependency area such as ICU, HDW and CCU
- Admission counter
- Medical Store

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

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

vi. All security personnel shall be vetted by the Ministry of Home Affairs or PDRM to ensure there are no security personnel with criminal records. Security personnel should undergo medical examination to ensure they are fit to perform their duties.

vii. The security personnel must develop a structure and mechanisms to work closely with the police and fire brigade and other related agencies.

viii. Appropriate technologies can be used such as electronic access card, security camera and automatic parking gates.

13.2 Outsourced Catering Services

i. Production and supply of diet shall be carried out by the appointed outsourced food service company. It shall be accountable to the Dietetic and Catering Department of the respective hospital.

ii. Foods shall be prepared according to the Privatized Food Service Contract Specification prepared by Ministry of Health.

iii. Serving of patients' diet shall be done on a fully centralized plating system.

iv. All kitchen facilities and equipment are government's asset and rented to the outsourced Health food service company. Maintenance of equipment shall be done by the hospital concession company. Payment for the utilities used by the company shall be made to the hospital.

v. The hospital Catering and Dietetic department shall ensure:

- that raw food material received are of accepted standard and stored properly to prevent contamination and rapid deterioration.
- Scheduled samplings of raw and cooked foods shall be collected at regular intervals and send to the Food Labs for analysis.
- that food handlers are vaccinated and trained to ensure quality of food provided.
- food preparation are in compliance with the MOH guidelines (HACCP).

13.3 Hospital Support Service

13.3.1 General

i. The following 5 support services shall be privatized in accordance to the specifications in the contract prepared by the Ministry:

- Cleansing
- Linen
- Waste management
- Biomedical engineering
- Facility engineering

ii. The administration unit shall be responsible for the overall coordination of the 5 services. A Liaison Officer for each service shall be appointed to monitor and coordinate all the activities and to ensure compliance to the Technical Requirement and Performance Indicators (TRPI), the Master Agreed Procedures (MAP) and the Hospital Specific Implementation Plan (HSIP). The HSIP is a dynamic document that shall be reviewed clearly and may be amended when necessary and endorsed by the hospital director.

iii. The overall coordinator shall have regular meetings with the liaison officers to discuss issues and remedial action to be taken to improve the services.

iv. There shall be a committee to discuss and decide on deductions for nonconformance.

v. The hospital engineering section/unit is technically responsible to monitor, evaluate, verified work done and deduction to the concessions company.

13.3.2 Cleansing

i. Cleansing shall be carried out in accordance to the schedule as agreed in the Hospital Specific Implementation Plan (HSIP).

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

13.3.3 Linen Services

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

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

iii. Supply of clean linen shall be on a top-up basis and comply with par level of each ward/unit/department/OT as agreed in the HSIP.

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

13.3.4 Waste Management

i. Waste shall be handled in accordance with standard precaution and infection control measures.

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

iii. The chemical waste shall be handled appropriately in accordance to the requirement of "Environmental Act 1974" and Environmental Quality (Scheduled Waste) Regulations 1989.

iv. "Guidelines on the Disposal of Chemical Wastes from Laboratories, 200 by Department of Environment, Ministry of Science, and Technology & Environment, Malaysia" shall be referred to for detailed procedures in handling of chemical waste.

13.3.5 Facility & Biomedical Engineering

i. The concession company shall be responsible for carrying out planned preventive maintenance according to the schedule recommended by the manufacturers of equipment.

ii. The regular maintenance service of mechanical, electrical, civil and biomedical equipment within the warranty period shall be undertaken by the vendors through Hospital Support Service.

iii. The Hospital Support Service shall rectify any breakdown within the shortest possible time as specified in the TRPI.

iv. Any improvement/alteration work and reimbursable work required shall be referred to the Hospital Director for approval.

14. DISASTER MANAGEMENT

14.1 Disaster Plan

i. There shall be an Emergency Management Committee headed by the Hospital Director. The members of the committee shall include the clinicians, representatives from the relevant department/unit and representative from the privatized support services.

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

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

iv. The Disaster Management Plan shall include the followings:
   - The emergency alert system
   - List of posts and responsibilities
   - Medical teams
   - Management of the victims
   - Documentation and statistics

v. All staff shall be briefed on the Disaster Management Plan and their roles and responsibilities. Appropriate training shall be carried out at planned intervals.

vi. A disaster drill shall be organized regularly at least once a year.

vii. Department and unit head shall be responsible for the disaster plan of their own department/unit.

14.2 Hospital Evacuation

i. The hospital shall have a plan for evacuation of building.

ii. Staff shall be brief on the evacuation plan, exit routes and the gathering site.

iii. An exit route plan shall be displayed at strategic location in every department/unit/ ward.

iv. An evacuation drill shall be carried out at least once a year.

v. Movement of personnel, patients and visitors from any part of the hospital made quickly and safely to the 'PLACE OF GATHERING' after the declaration of building erection.

vi. Everyone MUST use the designated exit and safety steps and obey the Officer in charge instructions.

vii. Everyone need to head to the 'PLACE OF GATHERING' as directed by the Officer in charge in accordance with the building stages and gather based on Department/Unit.

viii. The Officer in charge is responsible for carrying out the roll-call process with the assistance of the Head of Unit / Ward involved.

14.3 Specific Contingency Plans

i. A specific contingency plan shall be made available for the following situation:

- Power failure
- IT system breakdown
- Lift breakdown
- Disruption in water supply
- Gas leakage
- Flood
- Disease outbreak
- Air condition failure
- Building infestation
- Mass casualty
- Earth quake
- Telecommunication failure (PABX shutdown)

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

iii. All staff shall be briefed on the plan and appropriate training shall be carried out.

15. INFORMATION AND COMMUNICATION TECHNOLOGY (ICT)

i. Hospitals shall ensure that the Information Technology (IT) systems comply with all standards, policies, guidelines of the Ministry of Health and the central agencies such as *Jabatan Digital Negara.*

ii. Hospitals shall ensure that the IT staffs are able to support the system to enable the hospital to perform its function and daily operations i.e. IT staff is required to understand the applications and the operational procedures and processes.

iii. Maintenance for the IT system shall be carried out regularly. Maintenance implementation methods are preventive maintenance, corrective maintenance and operational and technical support services. These include hardware, software, applications, network, and security. Software applications and system shall require upgrading at intervals/kept current.

iv. Protect official secret information *(maklumat rahsia rasmi)* and government official information *(maklumat rasmi kerajaan)* from unauthorized access.

v. For hospitals with HIS system installed, operation and maintenance of ICT service shall be carried out by appointed company who is accountable to ICT Department of the respective hospital.

16. BUSINESS CONTINUITY PLAN FOR HIS SYSTEM DOWN

It is a management document for how and when to utilize resources needed to maintain selected functions when disrupted by agreed upon incidents. It is also known as Recover Plan. There are two categories which are Expected or Scheduled System Downtime and Unexpected or Unscheduled System Downtime. Preparation for Downtime include pre-, during and post downtime.

Pre downtime includes schedule for staff training, schedule for equipment checking (daily), computers, prepare and check BCP kit according to departmental needs and checklist. **During downtime** when an event identify by user - if PC failure, to inform Helpdesk 2113/2114. Head of Department to activate the BCP, print patient data from the contingency PC (ONLY if NEEDED), use the BCP kit, use manual for all procedure and to call lab to get all investigation result, if not urgent PPK can get the result.

Post Downtime, the management need to key in the data within 24 hours, to call I.T for synchronization of data, to top up BCP kit, rechecking PC and printer, to assign staff to enter all data and call extra staff if necessary and to prepare a hardcopy to be put into the BHT and send to Medical Record Office once patient discharge.

BCP kit contain a cabinet, documents - Admission Form, Census Book, Clerking Sheet, Continuation Sheet, Orientation Checklist, Observation Chart, Investigation Form, Referral Form, Diet Form, Medication Slip, Blood Transfusion Form, Indent and Dispatch book and stationary with special rubber stamp BCP.

Contingency Files is a summarization of patient records in the hospital that provides continuing hospital functionality in the event of the inevitable computer system failure. The existing patient and other critical data will be preserved on individual workstations in relevant departments. Data will consist of selected summary material created as a disk file report in an HTML (web) format and stored on the local drive of the relevant workstation. The frequency storage of the summary files is broken down into 3 different categories, every 24- hour, 6-hour or 1 hour. This will minimize down time and data loss.

17. PLANNING AND DEVELOPMENT

i. Every clinical head of department shall plan existing clinical development that includes short term and long term plan.

ii. Hospital should have master plan that describes the future needs of the service based on situational analysis done at inception/current status which shall includes service, physical and financial requirement.

iii. A short term of planning and development should be developed yearly (1–5 years) to address current needs of services and possible expansion.