MEDICAL PROGRAMME
MINISTRY OF HEALTH MALAYSIA

GENERAL HOSPITAL OPERATIONAL POLICY

THIRD EDITION 2025

General Hospital Operational Policy
Third Edition, 2025

ISBN 978-629-95335-0-4
eISBN 978-629-95355-1-1
MOH/P/PAK/569.25(HB)

© Hospital Services and Management Unit
Medical Development Division 2025
All rights reserved.

Published by
Hospital Services and Management Unit
Medical Development Division
Ministry of Health Malaysia
Level 5, Block E1, Complex E
Federal Government Administrative Centre
62590 Putrajaya, MALAYSIA
Tel: +603 8888 1139
Website: www.moh.gov.my

Designed by
Lakar Preenz Design

All rights reserved. This book may not be reproduced, in whole or in part, in any form or means, electronic or mechanical, including photocopying, recording or any information storage and retrieval system now known or hereafter invented without written permission from the publisher.

Printed in Kuala Lumpur

Cataloguing-in-Publication Data

Perpustakaan Negara Malaysia

A catalogue record for this book is available from the National Library of Malaysia

ISBN 978-629-95335-0-4

Contents

General Hospital Operational Policy
Third Edition 2025

04 Management and Operations

05 Hospital Governance

06 Human Resource Governance

07 Patient Governance

08 Clinical Governance

09 Disaster Management

10 Planning Development

FOREWORD

DIRECTOR GENERAL OF HEALTH MALAYSIA

DATUK DR MAHATHAR BIN ABD WAHAB

The evolution of medical services over the years has profoundly influenced patient care and hospital governance. As technology continues to advance rapidly, it is important for healthcare providers to adapt and refine their practices to remain effective and relevant.

In this regard, I am pleased to announce the revision of the General Hospital Operational Policy (GHOP) handbook, an initiative led by the Medical Programme. This updated edition is designed to support healthcare professionals in managing daily hospital operations more effectively. While the handbook provides a standardized framework, each hospital is encouraged to tailor these policies to meet local needs, with any modifications clearly justified.

As a dynamic and living document, the GHOP will be updated periodically to reflect new developments in medical technology and best practices. I urge all hospital administrators and healthcare providers to stay informed of these updates and incorporate them into their operational strategies.

I commend the Medical Programme and the Drafting Committee for their dedication in developing this comprehensive reference. I am confident that this handbook will serve as a valuable resource for those involved in the management and delivery of hospital services.

Datuk Dr Mahathar bin Abd Wahab
Director General of Health Malaysia
Ministry of Health, Malaysia

PREFACE

DEPUTY DIRECTOR GENERAL OF HEALTH (MEDICAL)

DATO' INDERA DR NOR AZIMI BINTI YUNUS

Welcome to the General Hospital Operational Policy (GHOP) handbook, crafted to guide and support our healthcare providers in delivering outstanding patient care. This handbook consolidates the policies and procedures essential for safe, effective, and compliant healthcare operations across various departments.

In today's fast-paced healthcare environment, clear and consistent policies are crucial for maintaining high standards. This handbook serves as a central resource, covering key areas from patient care protocols to administrative processes, ensuring a unified approach.

Developed with input from frontline staff, administrators, and subject matter experts, this handbook reflects the diverse expertise within our team. While it provides a structured framework, we recognise that healthcare is ever-changing. Therefore, we have established a process for regular updates to keep our policies relevant in light of new challenges and best practices.

My heartfelt thanks go to everyone involved in creating this handbook. Your dedication to excellence shines through, and I trust this will be a valuable resource for our organisation as we continue to deliver compassionate, patient-centred care.

Dato' Indera Dr Nor Azimi binti Yunus
Deputy Director General of Health (Medical)
Ministry of Health, Malaysia

PREFACE

DIRECTOR OF MEDICAL DEVELOPMENT DIVISION

DATO' DR MOHD AZMAN BIN YACOB

The Medical Development Division of the Ministry of Health (MOH) first introduced the General Hospital Operational Policy (GHOP) in 2013. Three years later, in response to the growing use of the Hospital Information System (HIS) and advances in digital technology, we launched an updated version tailored for Information and Communication Technology (ICT) environments in 2016. Now, in 2025, I am proud to present this third edition of GHOP, which unifies previous documents to cater to both HIS and non-HIS hospitals or institutions.

This latest edition aims to provide clear guidance and standardisation for healthcare service delivery in MOH hospitals. It is designed to help doctors, nurses, and all healthcare staff better understand their roles and responsibilities, ensuring consistent and effective practices throughout our facilities. Within this document, you will find comprehensive policies on hospital management and clinical governance, as well as disaster response and contingency planning. Feedback from healthcare professionals has been invaluable in shaping this edition, allowing us to refine the policies while preserving their core principles.

We hope this GHOP edition serves as a practical guide for hospital management teams, supporting our shared goal of achieving excellence in healthcare and delivering safe, high-quality care to all.

Dato' Dr Mohd Azman Bin Yacob
Director of Medical Development Division
Ministry of Health, Malaysia

The HIPPOCRATIC OATH

I swear to fulfill, to the best of my ability and judgment, this covenant:

I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.

I will apply, for the benefit of the sick, all measures [that] are required, avoiding those twin traps of overtreatment and therapeutic nihilism.

I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.

I will not be ashamed to say, "I know not," nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery.

I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.

I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems if I am to care adequately for the sick.

I will prevent disease whenever I can, for prevention is preferable to cure.

I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.

If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.

ADVISORS, EDITORS & CONTRIBUTORS

ADVISORS

Dato' Indera Dr Nor Azimi binti Yunus
Deputy Director General of Health (Medical)

Dato' Dr Mohd Azman bin Yacob
Director
Medical Development Division

EDITORS

Dr Mohd Ridzwan bin Shahari
Senior Principal Assistant Director
Medical Development Division

Dr Gunenthira Rao a/l Subbarao
Senior Principal Assistant Director
Medical Development Division

Dr Tuan Norfadhlina binti Tuan Mustapa
Senior Principal Assistant Director
Medical Development Division

Dr Muhammad Zulfakhar bin Zubir
Senior Principal Assistant Director
Medical Development Division

Dr Basyir bin Kamaruzaman
Senior Principal Assistant Director
Medical Development Division

REVIEWERS

Dato' Dr Fazilah binti Shaik Allaudin
State Health Director
Pulau Pinang State Health Department

Dr Zulhizzam bin Hj. Abdullah
Director
Public Health Development Division

Dr Mohd Anis bin Haron @ Harun
Former Director
National Cancer Institute

Dr Muhammad Yusof Sibert
Deputy State Health Director (Medical)
Kuala Lumpur and Putrajaya Health Department

CONTRIBUTORS

Dato' Indera Noridah binti Abdul Halim
Chief Secretary
Ministry of National Unity

Haji Ruslan bin Saidi
Deputy Director General (Operation)
Department of Islamic Development Malaysia

Dr Mohamed Iqbal bin Hamzah
Former Director
Medical Practice Division

Pn. Fuziah binti Abdul Rashid
Former Director
Pharmacy Practice and Development Division

Dr Goh Cheng Soon
Director
Traditional and Complementary Medicine Division

Dr Nor Hayati binti Ibrahim
Senior Deputy Director
Medical Services Development Section
Medical Development Division

Dr Hirman bin Ismail
Deputy Director
Medical Profession Development Section
Medical Development Division

Dr Azlihanis binti Abdul Hadi
Deputy Director
Medical Care Quality Section
Medical Development Division

Pn. Ong Ling Loong
Deputy Secretary Division
Finance Division

Datuk Dr Abdul Kahar bin Abd Asis
Deputy State Health Director (Medical)
Sabah State Health Department

Dato' Dr Teo Gim Sian
Former Deputy State Health Director (Medical)
Pulau Pinang State Health Department

Dato' Dr Wan Abdul Rahim bin Wan Muhamad
Deputy State Health Director (Public Health)
Pahang State Health Department

Dr Mohamad Zamri bin Kamis
Deputy State Health Director (Medical)
Perlis State Health Department

Dr Farique Rizal bin Abd Hamid
Director
Sultan Idris Shah Hospital, Selangor

Dr Roniyuzam Abdul Malek
Deputy State Health Director (Medical)
Perak State Health Department

Dr Faizal bin Mat Ariffin
Deputy State Health Director (Medical)
Selangor State Health Department

Dr Shahrum bin Hj Arshad
Director
Melaka Hospital, Melaka

Dr Sal binti Atan
Former Deputy State Health Director (Medical)
Johor State Health Department

Dr Rohana binti Daud
Deputy State Health Director (Medical)
Kelantan State Health Department

Dr Azlee bin Ayub
Deputy State Health Director (Medical)
Sarawak State Health Department

Dr Adilah binti A. Bakar
Senior Principal Assistant Director
Medical Development Division

Dr Suriana Aishah binti Zainal
Senior Principal Assistant Director
Medical Development Division

Dr Jafanita binti Jamaludin
Deputy State Health Director (Medical)
Pahang State Health Director

Dr Md Anuar bin Abd Samad @ Mahmood
Senior Principal Assistant Director
Medical Development Division

Dr Shahanizan binti Mohd Zin
Senior Principal Assistant Director
Medical Development Division

Dr Azkhaire bin Anor Basah
Senior Principal Assistant Director
Medical Development Division

CHAPTER

01 INTRODUCTION


HOSPITAL KUALA LUMPUR

01 Introduction

1.1 OVERVIEW

The General Hospital Operational Policy (GHOP) provides a comprehensive guide outlining the operational framework for public hospitals and specialised institutions under the Ministry of Health Malaysia (MOH).

It offers clear directives and guidelines to support the effective management of hospital or institution operations while aligning with MOH's overarching vision and goals.

1.2 PURPOSE

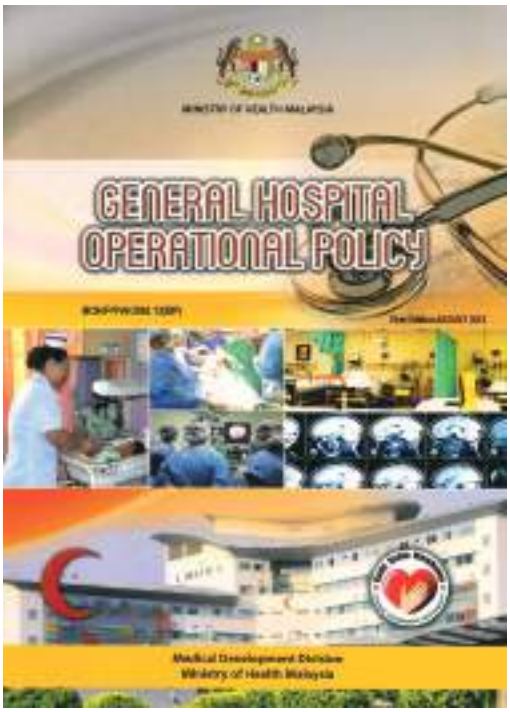
The primary aim of the GHOP is to establish a structured framework to guide hospital or institution management teams in overseeing and improving hospital operations.

This policy ensures consistency and the delivery of high-quality healthcare services by adhering to MOH's vision, mission, and objectives.

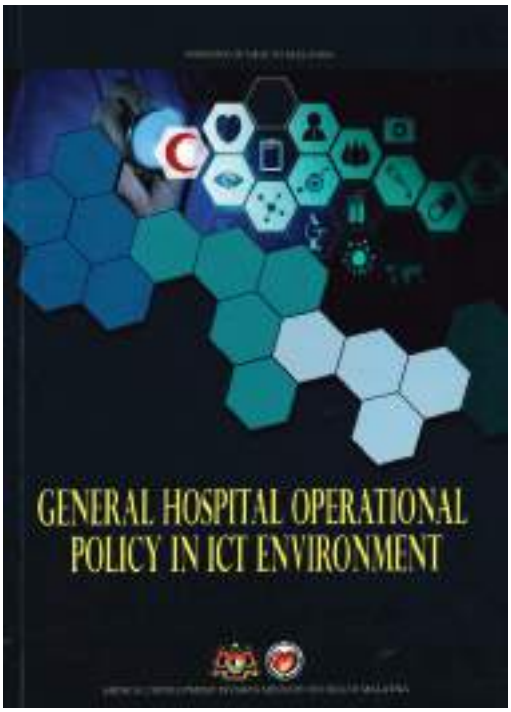
The GHOP is subject to review to ensure it remains relevant and adaptable to the dynamic needs of healthcare delivery.

This document marks the third edition of GHOP 2025 reflecting advancements and evolving healthcare priorities.

- The first GHOP was introduced in August 2013.
- The second edition, titled General Hospital Operational Policy in ICT Environment, was published in November 2016.



FIRST EDITION GHOP 2013



SECOND EDITION GHOP 2016

1.3 APPLICABILITY

The GHOP applies to all services, departments, and personnel within public hospitals or institutions and specialised institutions under the MOH. It extends to visitors and contractors accessing MOH-managed facilities, including temporary or mobile setups, ensuring consistency and adherence across all operational areas.

1.4 SCOPE

The requirements outlined in this policy apply to all employees, visitors, and contractors associated with MOH facilities. The GHOP establishes a cohesive and well-regulated operational environment, empowering MOH hospitals or institutions to deliver equitable, high-quality healthcare that effectively meets the needs of the Malaysian population.

CHAPTER

02 ORGANISATIONAL OVERVIEW


HOSPITAL TENGKU PERMAISURI NORASHIKIN
(PUSAT RAWATAN WANITA DAN KANAK-KANAK)
LALUAN BOMBA
KOSONGKAN

02 Organisational Overview

2.1 MOH OBJECTIVE, VISION AND MISSION

2.1.1 Objective

To assist any individual to achieve and maintain a standard of health which would enable him or her to lead a productive economic and social life. This can be achieved by providing efficient, appropriate and effective promotion, prevention, treatment and rehabilitation services with an emphasis on the disadvantaged groups.

2.1.2 Vision

A nation working together for better health.

2.1.3 Mission

The mission of the MOH is to lead and work in partnership;

a to facilitate and support the people to;
- i. attain fully their potential in health;
- ii. appreciate health as a valuable asset; and
- iii. take individual responsibility and positive action for their health.

b to ensure a high-quality health system that is;
- i. customer-centred;
- ii. equitable;
- iii. affordable;
- iv. efficient;
- v. technologically appropriate;
- vi. environmentally adaptable; and
- vii. innovative.

c with the emphasis on;
- i. caring, professionalism and teamwork;
- ii. respect for human dignity; and
- iii. community involvement.

2.2 HOSPITAL OR INSTITUTION OBJECTIVE, VISION AND MISSION

CHAPTER

03 ORGANISATIONAL ADMINISTRATION


HOSPITAL

03 Organisational Administration

3.1 ORGANISATIONAL STRUCTURE

The organisational structure of the hospitals or institutions may differ according to the type of hospital or institution and the number of deputy directors as stipulated in **Appendix 1-4**.[1]

a A Hospital or Institution **Director**, who shall be a medical doctor, shall lead the overall management. The Hospital or Institution Director shall be supported by a Deputy Hospital or Institution Director or Senior Administrative Medical Officer, who shall be further supported by the heads of clinical and non-clinical departments or units.

b The **clinical departments** or **units** shall be overseen by the resident specialists or visiting specialists subjects to approval and in the absence of the specialists, by the medical officers. The non-clinical departments shall be led by the officers trained in their respective disciplines.

c The **nursing services** shall be supervised by a Matron Nurse and in the absence of the Matron Nurse, by a Sister Nurse. Their responsibilities shall include the oversight of areas such as the Central Sterile and Supply Department (CSSD) or Unit (CSSU), laundry and linen services, infection control and the nurses' hostel, if available.

d The hospital or institution **supervisor** shall be responsible for coordinating services provided by the Assistant Medical Officers (AMO/PPP) and Healthcare Assistants (PPK). In addition, he or she shall be responsible for services related to ambulance, transport and porter services as well as for looking after the environment, health and safety aspects including fire safety and disaster management.[2,3]

e The **administrative departments** shall be headed by the administrative officers trained in areas such as general administration, human resources, finance, asset, revenue, Information and Communication Technology (ICT), privatised services, premises and security.

f The hospital or institutional **support services** are an essential part of Facilities Maintenance Management (FMM), providing infrastructure and operational support to ensure the safe, efficient, and uninterrupted delivery of healthcare services. The hospital or institution shall be responsible for the overall coordination of the services.

g The **engineering services** shall be headed by an engineer or assistant engineer and supported by technicians. They shall be responsible for overseeing areas related to the privatised services, including the hospital or institution waste management, fire safety, maintenance of grounds, landscaping, and maintenance and repair of civil, mechanical, electrical and biomedical installations.

3.2 ADMINISTRATION

The hospital or institution management shall be responsible for maintaining the operation and records of each department or unit, which may encompass the following key components:

Components	Details
Background	An outline of the hospital or institution history, establishment and significant milestones.
Facilities Available	Details of the infrastructure, medical equipment and specialised units or departments within the hospital or institution.
Services Provided	A comprehensive list of clinical services offered, including primary care, specialised treatments and allied health services.
Human Resource	Information regarding the hospital or institution's workforce, including medical professionals, nursing staff, administrative personnel and support staff.
Performance	Documentation of the achievements by the hospital, along with challenges, quality, performance and other related records.
Way Forward	Plans and strategies for future development and improvement initiatives aimed at enhancing patient care and overall hospital performance.

3.3 COMMITTEES

a. The hospital or institution shall establish various committees as mandated by the MOH.

b. All committees shall be chaired by the Hospital or Institution Director or an officer appointed by the director unless stated otherwise. The members shall consist of officers from relevant departments and units. Each committee shall have its own terms of reference.

c. The number of committees established shall be based on the local needs of each hospital or institution.

d. The Hospital or Institution Director shall chair the following meetings:
   i. Clinical or Technical Committee;
   ii. Hospital or Institution Management Committee;
   iii. Rules and Regulations Committee;
   iv. Quality Initiatives Committee; and
   v. any other relevant committees.

Examples of committee lists are as shown in **Appendix 5**.

1 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 5, Tahun 2025 – Struktur Organisasi dan Tadbir Urus Klinikal (Clinical Governance) bagi Hospital-hospital Kementerian Kesihatan Malaysia, bertarikh 21 Januari 2025.*

2 *Polisi Operasi Unit Penyeliaan Penolong Pegawai Perubatan (Hospital), Edisi Pertama, Mac 2015.*

3 *Surat Edaran Ketua Pengarah Kesihatan – Pelantikan Ketua Penyelia Penolong Pegawai Perubatan Sebagai Pegawai Keselamatan Kebakaran (Fire Safety Officer-FSO) di Hospital/Pejabat Kesihatan Daerah/Institusi Kementerian Kesihatan Malaysia, bertarikh 5 Jun 2017.*

CHAPTER

04 MANAGEMENT AND OPERATIONS


CHTAA
1123109/MYS.060404.BM0021
HOSPITAL TENGKU AMPUAN AFZAN KUANTAN
هوسڤيتل تڠكو ا ان أفزان كوانتن
KKM
KUALITI SEPANJANG MASA

04 Management and Operations

4.1 PUBLIC MANAGEMENT

4.1.1 Information Counter

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

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

4.1.2 Operating and Visiting Hours

a. **Visiting Hours**

i. The visiting hours shall be determined by the hospital or institution management depending on the current health situation such as during the pandemic or any other government direction or order.

ii. Generally, the visiting hours shall be as following:

Day	Weekdays	Weekend & Public Holidays*
Time	12.30 PM — 2.00 PM 4.30 PM — 7.00 PM	12.30 PM — 7.00 PM

* Weekend = According to State Government Policy

b. **Other Visiting Policy**

i. During visiting hours, the visitors shall be allowed to visit patients in the general wards except in the event of an outbreak or emergency.

ii. Only two (2) visitors shall be allowed to visit at any given time.

iii. Children aged below 12 shall not be allowed to visit patients in the hospital or institution.

iv. In special units such as Intensive Care Unit (ICU), Coronary Care Unit (CCU), High Dependency Ward (HDW), and Burn Unit, only two (2) visitors shall be allowed at any one time and the duration of the visit shall be determined by the policy of each ward.

v. No visitors shall be allowed to visit patients in any isolation rooms.

vi. Only parents shall be allowed to visit patients in Pediatric Intensive Care Unit (PICU), Neonatal Intensive Care Unit (NICU) and Special Care Nursery (SCN).

vii. During health emergencies such as disease outbreaks (e.g., COVID-19, H1N1) or disasters, visiting hours shall be adjusted by the management to contain the spread of diseases and prevent overcrowding in wards.

viii. The hospital or institution shall not be held accountable for lost items, accidents, or infections acquired during or after visits (hospital acquired infections).

ix. All patients, family members or visitors shall respect the staff and shall give cooperation to them while they are in the hospital or institution. They shall be prohibited from using violence either physical or verbal against any staff.[1]

c Extended Visiting

i. Generally, no visitors shall be allowed after the visiting hour.

ii. In certain circumstances visiting patients may be allowed but it shall be subject to the patient's condition and the respective hospital policy.

iii. All visits outside visiting hours shall be recorded.

iv. In general, only one (1) caregiver shall be allowed to accompany a patient in the ward at any given time subject to the approval of the ward staff and this shall be subjected to the respective department and hospital or institution policy.

v. A special pass *(Pas Menunggu)* shall be issued in the following situation:

Individual	Situation
 A caregiver	To accompany critically ill or bedridden patients. Only female caregivers shall be allowed to accompany patients in the female ward or cubicle.
 A parent or legal guardian	To accompany children in the Paediatric wards. Age more than 18 years old.
 A single carer	A female carer is preferable to be with the child at all times or overnight.
 Parents or guardians	To accompany children in the Paediatric wards.
 Mothers of babies	Mothers of babies admitted to the special care nursery for breastfeeding.[2]
 Husband or patient's mother	Husband or patient's mother shall be allowed to accompany the patient in labour in the labour room but this shall depend on the local hospital or institution policy.

vi. No caretaker shall be allowed in the ICU, CCU, HDW, PICU, NICU, SCN.

vii. It is encouraged for the same person to accompany a patient in the ward.

d Other Protocols

i. Registered hospital volunteers shall be allowed entry from 10.00 AM to 8.00 PM, subject to scheduling and arrangements by the hospital or institution.[3]

ii. Members of the Board of Visitors with identification cards shall be allowed to enter the hospital or institution for formal duties.

iii. Very Important Person (VIP) on official visits shall be accompanied by the hospital or institution staff.

iv. Non-Governmental Organisations (NGOs) or associations must obtain permission from the Director to conduct activities or programs in the ward.

4.1.3 Dress Code

a. All visitors shall dress appropriately and shall respect Malaysia's multicultural practices and sensitivities.

b. While hospitals or institutions remain accessible to all, modest attire is encouraged to maintain a professional and comfortable environment for patients, staff, and other visitors.[4,61]

4.1.4 Mobile Phone

a. Mobile phones shall be prohibited in designated areas within the hospital or institution.

b. Signs prohibiting the use of mobile phones shall be placed in designated areas within the hospital or institution.[5]

c. Any recording made by patients, relatives or staff using mobile phones within the hospital or institution compound, intentionally or unintentionally, that may have negative implications for the hospital or institution shall not be allowed to be disseminated or published on any social media platform without permission from the Hospital or Institution Director.[6]

4.1.5 Recording or Filming

a. Recordings conducted for clinical purposes whether photography, filming, or interviews shall be considered part of a patient's medical record and shall be handled with the same confidentiality and care as other medical records.

b. Interviews, audio-visual or multimedia recordings of patients shall only be conducted with the consent of the patient and/or their relatives with approval from the Director.[6,7,8,9]

c. The video recording via video conference between the healthcare practitioners and patients' relatives shall be prohibited.

d. The commercial filming or shooting of dramas within the hospital or institution premises shall be discouraged. However, the Hospital or Institution Director may grant permission following the MOH guidelines, with exceptions made for MOH health promotion documentaries.

e. The hospital or institution staff, ambulances or equipment shall not be permitted for use in filming activities.

f. Signs indicating the prohibition of photography and video recording shall be conspicuously displayed at specified areas within the hospitals or institutions.[5]

4.1.6 Release of Information

a. The hospital or institution shall be prohibited from issuing statements on policy matters or matters of public interest to the public or the media.[10,11,12,13]

b. Patient information shall not be disclosed without prior written consent from the patient.

4.1.7 Public Facilities

a. Public facilities shall be managed by either the General Administration or the specific department where they are located and these facilities may include the following;
   i. visitor's lounge *(Anjung Kasih/Balai Pelawat);*
   ii. prayer room *(Surau);*
   iii. breastfeeding room;
   iv. cafeteria;

v. washrooms and toilets;
vi. shops or kiosks;
vii. automated teller machines or banking facilities;
viii. post office;
ix. police station, etc.

b The hospital or institution, provided with a visitor's lounge, shall keep the facility open 24 hours as a resting place for patients' relatives. Users of the lounge shall adhere to the hospital's rules and regulations.

c The prayer room (for Muslim only) shall be open 24 hours to the public and staff.

4.1.8 Car Park

a Parking facilities shall be provided for both staff and also the public.

b Only vehicles displaying hospital or institution stickers shall be permitted to access the staff parking areas.[14]

c Specific parking areas shall be designated for doctors on call and disabled patients, ensuring convenient access to the clinical areas.

d Parking spaces allocated for Persons with Disabilities (PWDs) within the hospital or institution premises shall adhere to the guidelines established by the Ministry of Housing and Local Government. The parking spaces shall be situated near building entry or exit points for ease of access.[15]

e The hospital or institution does not assume responsibility for the safety of vehicles parked on its premises.

f Signages shall be prominently displayed to notify the public that vehicles are parked at their own risk.

4.1.9 Volunteer

a Individuals interested in volunteering at the hospital or institution shall apply directly to the respective hospital through the Medical Social Work Officer, adhering to the required procedure for approval, with appointments lasting a maximum of two (2) years.[3]

b A designated coordinator, such as a Medical Social Work Officer, shall guide the volunteers in their duties and shall monitor their services.

c The volunteers shall serve from 10.00 AM to 8.00 PM and shall comply with the hospital or institution rules and regulations while maintaining professionalism.

d The volunteers shall be prohibited from using any MOH hospital names for business purposes.

e The hospital or institution names shall also not be used for the naming of hospital volunteer groups that establish special associations, clubs or organisations.[16]

4.1.10 Management of the Deceased

a. The hospital or institution shall prepare the deceased based on the clinical requirements and guidelines.[63]

b. Following the completion of the relevant clinical guidelines and appropriate documentation, the hospital or institution shall transfer the deceased to the family members or carers.

c. Family members or carers shall be responsible for contacting funeral services according to their preferences or religious practices.

d. The role of the hospital or institution shall ends with the handover of the deceased to the next of kin or appointed guardian.

e. Funeral management shall adhere to the Code of Ethics and Conduct of the MOH. Hospital or institution staff shall be strictly prohibited from accepting any form of gifts or imposing any charges for funeral management services. This is to prevent any misuse of power or elements of corruption.

4.1.11 Grievances, Complaints and Feedbacks

a. The management shall establish a system to address client grievances including complaints promptly and effectively. The Customer Feedback Management shall be handled efficiently and systematically.

b. The General Administration Unit shall be tasked with monitoring all grievances including comments or complaints. Upon receiving the grievances it shall be promptly forwarded to the Director and the relevant department or unit for further action.

c. The grievances may originate from various sources either verbal, written or media complaints.

d. Grievances shall be categorised as clinical or non-clinical, including medicolegal and non-medicolegal issues, and shall be managed based on urgency, regardless of the source.

e. All received grievances shall be documented, investigated and appropriate action shall be taken as stipulated in the guideline.[17,18,19]

4.2 GENERAL ADMINISTRATION

4.2.1 Letters and Documents

a. The General Administration Unit shall be tasked with managing all incoming and outgoing official letters and email communications.[21,62]

b. A standardised filing system for the official documents shall be implemented throughout the hospital, encompassing both physical and digital formats for incoming and outgoing correspondence.[22]

c. The digital copies of all official letters shall be stored in the Digital Document Management System (DDMS) for easy retrieval and tracking.[23]

d. Upon receiving, incoming letters and documents shall be logged, minute records maintained and promptly forwarded to the respective department or unit within the stipulated time frame.

e. All official outgoing correspondence shall bear the standardised hospital letterhead.

f. Internal memos shall be utilised for circulating letters intended for internal distribution.

g. Correspondence and documents designated under the Official Secrets Act shall be strictly handled in accordance with the provisions of the Act and segregated accordingly.[20]

h. The retention periods for letters and documents shall be adhered to, with disposal procedures conducted in compliance with the guidelines prescribed by the National Archive Department *(Jabatan Arkib Negara)*.[24,25]

4.2.2 Office Equipment and Supplies

a. The General Administration Unit shall oversee the procurement of office equipment and stationery for the hospital or institution, ensuring their distribution to respective units and departments.

b. The Heads of Departments or Units shall be tasked with maintaining accurate records of assets and inventory using the *Sistem Pengurusan Aset Alih* and *Sistem Pengurusan Stor*, thereby ensuring proper utilisation of equipment and supplies.[26,27]

c. Certain office equipment may be designated for shared use among multiple departments or units. The departments or units housing the shared equipment shall bear responsibility for its proper management and maintenance.

d. The Asset Management Unit or Committee shall assume responsibility for various functions, including the receipt, registration, utilisation, safekeeping, inspection, maintenance and disposal of assets.

4.2.3 Meeting Room

a. An assigned individual or unit shall oversee the scheduling and utilisation of meeting rooms and other facilities, such as the auditorium and seminar rooms.[29,30]

b. Meetings shall be efficiently organised and documented, with the option for virtual participation, where feasible.[31,32]

c. Advance notice shall be given through call letters and meeting minutes shall be disseminated within a specified timeframe. A copy of the minutes shall be archived in the appropriate file.[28]

4.2.4 Naming of Facilities

The naming of all federal government buildings, including hospitals or institutions and their facilities, shall adhere to the following guidelines:

a. They may be named after the noble name of the king;

b. They may be named after influential national leaders (deceased); and

c. Alternatively, names such as those of flowers, fruits, or animals may be used, provided they are appropriate and in line with the regulations.[33]

4.2.5 Signage

a. All signages within the hospital or institution shall primarily use *Bahasa Melayu* as the national language.[34]

b. The use of other languages, including those spoken by Malaysia's various ethnic groups shall not be forbidden.

c. These languages may be employed as needed, but they shall be less prominent in terms of size, colour, etc.

4.3 FINANCE

4.3.1 Budget Allocation and Expenditure

a. Funds allocated to the hospital or institution shall be designated according to the needs.

b. The head of each activity shall be responsible for drafting the programme agreement, conducting evaluations and preparing exceptional reports, if necessary, by the end of the budget year.

c. The head of each activity shall provide justifications for any additional budget requirements.

d. A Finance Committee shall be established to address financial and accounting matters, including expenditure status, budget reallocation and additional requirements. The Hospital Director shall bear the full responsibility for managing the allocation and expenditure of the hospital or institution.

4.3.2 Procurement

a The procurement of the hospital or institution supplies or specific items shall be coordinated by the relevant department.[35]

b The procurement process shall involve the activation of three (3) committees namely the Specification, Technical and Financial Committees. To ensure compliance with the Treasury Instructions, the Hospital Management Committee shall establish a system based on the following;

i. public accountability;
ii. transparency;
iii. value for money;
iv. open and fair competition; and
v. fair dealing.

c All procurements related to ICT shall require approval from the MOH and other relevant agencies.[36]

d The loaning of medical equipment to patients shall be based on patient selection as stipulated in the guideline.[37,38,39]

4.3.3 Claims and Loan

a All staff shall submit all claims within the first 10 days of the following month. All claims shall be completed, signed and accompanied by the required documents.[40]

b All Head of Department (HOD) or Unit shall be responsible for reviewing and approving claims before submission to the Finance Unit.

c Applications for the government or private loans shall be submitted based on eligibility criteria and accompanied by the necessary forms and documents. The HOD or Unit shall verify these submissions.

4.3.4 Charges

a All charges shall be charged in accordance to the following:

i. Fee (Medical) Order 1982 (Amendment) 2017;
ii. Fee (Medical) (Amendment) (Foreigner) Order 2014;
iii. Fee (Medical) (Full Paying Patient) Order 2007; and
iv. Ministry of Finance (MOF) Circulars.

b For procedures and investigations which are not listed in the Fee (Medical) Order may be submitted to the Finance Division of the MOH for fee approval. This involves submitting a paper proposal, preparing a *Memorandum Jemaah Menteri* (MJM), and obtaining approval from members of Parliament before it is gazetted. The hospital or institution shall disseminate information on hospital fees or charges to all relevant parties.

c Deposits shall be collected before admission, except for emergency cases where deposits may be collected later.[41]

d All hospitals or institutions shall take all necessary measures to collect payments from the patients.

e Any exemption of payment for certain groups of Malaysian patients shall be considered by the Hospital or Institution Director for outpatient and third-class ward patients. In other cases, fee exemption approval may be granted in accordance with the Treasury Instructions or MOH Circulars and the Fee (Medical) Order 1982.[42,43]

4.3.5 Billing and Payment

a All paying patients shall receive their hospital bill upon discharge and shall be required to settle the bill at the revenue counter. An interim bill may be provided one (1) day prior to discharge, and long-staying patients may be informed of their accumulated bill at intervals. Additional deposits shall be collected if the interim bill exceeds the initial deposit.

b For hospitals or institutions with HIS, an interim bill may be generated upon request. The system can automate the flow of chargeable events to future billing or manually add charges to certain modules in HIS for modular usage.

c For any patients with a valid Guarantee Letter (GL) from private companies, state government officers, statutory bodies or local authorities, hospital bills shall be sent to the employer. The Revenue unit staff shall refer to the e-GL through Human Resource Management Information System (HRMIS) for federal civil servants and their dependants.

d All hospitals or institutions shall be encouraged to collect revenue from patients using cashless payment methods available in the hospital or institutions. However, the hospitals or institutions may accept cash, money orders, postal orders, bank drafts or banker's cheques if requested by patients. Receipts shall be issued upon payment.[44,45]

e Revenue collection shall only be conducted by authorised staff at designated revenue counters.

4.4 TRANSPORT SYSTEM

4.4.1 General Transport System

a The hospital or institution shall operate ambulance services for patients and the public, as well as transportation for both patients and staff. All ambulances and other vehicles shall be meticulously maintained and kept in operational condition at all times.

b The hospital or institution vehicles shall be designated for specific purposes as follows:

Vehicles	Purpose
Ambulances	Dedicated for pre-hospital care and inter-hospital patient transportation. Other vehicles shall not be modified or repurposed as ambulances due to concerns for patient and healthcare worker safety
Hearses	Solely used for the transportation of deceased
Vans	Utilized for the transportation of supplies and materials
Minibuses	Assigned for the transportation of staff, ambulatory patients and visitors
Saloon Cars	Designated for staff transportation
Lorries	Employed for transporting bulk items such as furniture and equipment

c The hospital or institution vehicles shall be operated by authorised hospital drivers holding valid driving licenses and they shall adhere strictly to the road traffic rules and regulations.[46]

d The ambulances shall fall under the purview of the ETD, where appropriate, the other vehicles shall be managed by the Administration Unit.

e Relatives shall be prohibited from accompanying patients in ambulances and if they do, they are required to sign an indemnity form. However, a parent or legal guardian may accompany pediatric patients.

f The occupancy of each vehicle shall adhere to the guidelines outlined in their respective manuals.

g The decision regarding the appropriate mode of transport during emergencies rests with the Hospital or Institution Director.

h Regular updates to the logbooks of all vehicles and ambulances shall be mandatory.

i The drivers shall be responsible for ensuring the regular cleaning and maintenance of all vehicles and ambulances.[47,48,49]

4.4.2 Central Porter System

a The central porters, if available, shall be tasked with the following responsibilities;
i. transfer of patients between wards and clinics; and
ii dispatch of medical records between wards, clinics and the Medical Record Unit.

b The central porter service shall operate from 7.00 AM to 5.00 PM or as determined by the hospital or institution management.

c In the absence of the central porters or outside of the operating hours, the responsibilities shall be undertaken or assumed by the PPK assigned to the specific wards or areas.

d A porter service manager shall be appointed to oversee and coordinate the operations of the central porter service.

4.4.3 Pneumatic System

a The pneumatic tube system shall be utilised for the transportation of pathology specimens, medications, documents and medical records, adhering to the weight limits specified by the system.

b Prior to transportation in the pneumatic tube, the items shall be placed in the designated special container provided.

c The department initiating the use of the pneumatic tube system (sender) shall bear responsibility for ensuring the proper and safe transfer of the items. In the event of delay or non-arrival at the receiving end, the sender shall undertake necessary efforts to trace the items.

d A list of items prohibited for transportation in the pneumatic tube system shall be identified by the hospital which shall include food, blood bags, urine specimens, etc.

4.4.4 Traffic Control

a. To mitigate traffic congestion, the hospital or institution shall establish a traffic management system. The road leading to the ETD shall be exclusively designated for ambulances and public or private vehicles transporting emergency cases for entry and exit purposes.

b. For patient convenience, designated drop-off and pick-up zones shall be established near the entrances to the Specialist Clinic, ETD and PAC, including the Labour Room.

c. Strict enforcement shall be in place to prohibit parking outside of designated parking areas.

d. If available, shuttle services shall transport staff, patients and relatives from a designated area to the hospital or institution at specific intervals. This service aims to alleviate congestion in the hospital or institution parking area.[14]

4.5 MANAGEMENT OF ASSETS

4.5.1 Procurement

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

b. Procurement of all medical items such as drugs, consumables, chemical reagents shall be coordinated by the Logistic Unit.

c. Procurement of office stationaries and other non-medical items shall be coordinated by the General Administration Unit and IT consumables by the IT unit.

d. Purchasing of food items shall be coordinated by the Catering Unit.

e. The application for ICT technical approval shall be based on the project value limit that has been set as well as monitoring the progress of development and implementation of ICT projects.[50,64]

4.5.2 Requirement and Specification

a. The requirement of medical equipment, consumables, drugs and pharmaceutical supplies shall be decided by the individual department or unit and shall be approved by the HOD and Hospital or Institution Director.

b. The respective HOD shall be responsible for preparing the technical specifications.

4.5.3 Delivery and Supply

a. Standard items shall be stored for four (4) calendar months supply and non-standard items shall be made available only upon request.

b. All pharmaceutical supplies shall be delivered to the Logistic Unit except for chemical reagents, which shall be sent directly to the Pathology Department. The supply of consumables shall be collected directly from the Logistic Unit and the supply of drugs shall be collected from the Inpatient Pharmacy.

c Bulky equipment shall be delivered directly to the respective end user. The end user and the Logistic Unit staff shall be present to verify the delivery.

d The HOD 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. The testing and commissioning process shall be carried out in the presence of the user, supplier and Asset Manager.

e The dangerous and psychotropic drugs shall be stored, transported and managed only by authorised staff.

f Items requiring refrigeration and inflammable or explosive materials shall be kept in the individual storage areas.

4.5.4 Equipment Inventory

a The hospital or institution and the individual departments or units shall maintain and update the equipment and inventory list and planned preventive maintenance schedule.

b Any equipment shall not be moved or transferred to another department or another hospital without prior approval of the Hospital or Institution Director. Any movement of equipment shall comply with the Guidelines on Asset Management and shall be documented.

c The loaning of equipment shall be limited to items needed immediately to ensure patient's safety and well-being, including equipment used directly and indirectly for patient care. Indirect patient care equipment shall include items needed to ensure the smooth, uninterrupted operations of the hospital or institution.

d Equipment may be loaned within the hospital or institution, inter hospital or inter cluster with the approval of the respective Hospital or Institution Director and CMC. There shall be no charge for loaned equipment.

e The loaned equipment shall be checked prior to delivery to ensure that it is operational. All returned equipment shall be inspected to ensure it is operational.

f Supplies may be loaned inter-hospital or inter-cluster and shall be replaced with an identical item or an item of equivalent value that is acceptable to the Lender. Delivery and return of the equipment or supplies shall be the responsibility of the borrower.

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

4.5.5 Disposal of Equipment

a. The HOD shall be responsible for submitting a list of equipment to be disposed of or condemned to the Finance and Account Unit.[26]

b. Any equipment which has been given the certificate of beyond economic repair (BER), shall be disposed accordingly and kept in a safe area or location prior to disposal.

c. Documentation of assets with respect to life span or sustainability shall be provided so as not to disrupt services.

4.6 COMMUNICATION SYSTEM

4.6.1 Hospital Information and Communication Technology

a. The IT Unit of HIS hospitals or institutions shall ensure that the HIS functions according to the standards, policies and existing guidelines of the MOH and the central agencies such as *Jabatan Digital Negara* (JDN).[21,51]

b. The Hospital or Institution Director shall ensure that the IT staff, system owners and hospital champions are able to support the system to enable the hospital or institution to perform its function and daily operations. The IT staff shall be required to understand the applications and the operational procedures and processes.

c. The maintenance for the IT system shall be carried out regularly and shall include preventive maintenance for both hardware and software. The software applications and systems shall require upgrading at intervals or kept current. ICT backup shall be made available and be kept in a hospital system.

d. Operation and maintenance of ICT service shall be carried out by an appointed company who shall be accountable and the IT Unit shall supervise the appointed vendor.

4.6.2 Telephone

a. Type 'A' line shall be made available to the Hospital or Institution Director as head of the organisation.

b. The Heads of Clinical Departments may be provided with a type 'B' Private Automatic Branch Exchange (PABX) line. Specific areas shall also be provided with a type 'B' line. All other telephone lines within the hospital or institution shall be of type 'C'.

c. The telephone shall be for official use only and the usage shall be monitored by the operators.

d. The use of mobile phones in critical areas within the hospital or institution shall be in accordance with existing MOH guidelines.

e. A two-way communication system shall be provided in the ambulances for communication between the ambulance and the base station in the ETD.

4.6.3 Email

a. Email shall be the main communication tool to be utilised.

b. MyGovUC integrated communication means a service consisting of various communication channels such as email, online conferencing, sending large files and group chats.[51]

4.6.4 Nurse Call System

a. A nurse call system shall be used as a communication tool between the patient and staff.

b. The nurse call system shall be provided to all beds for patients requiring assistance to use. As far as possible, the system shall be extended to other patient areas such as the washrooms and toilets.

c. Nurses shall attend to the patient immediately upon activation of the nurse call system.

4.6.5 Public Address System

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

b. The PA System may also be used for emergency situations using specific codes which shall be as the following:[52]

Code	Interpretation
Black	Bomb/CBRNE*-related security threats
Silver	Armed security threats/riots/hostages/terrorism
Grey	Security threats involving violent incidents with visitors/patients/staff
Orange	Security threats involving fire/emergencies in large-scale facilities
Green	Stand down
Red	Critical incidents involving pregnant women (i.e., eclampsia, etc)
Pink	Security threats of child abduction/missing children
Blue	Incidents of visitors/patients**/staff being unconscious
Purple	Incidents of visitors/patients/staff attempting or committing suicide

Note:
* CBRNE: Chemical, Biological, Radiological, Nuclear and Explosive.
** Patients refer to individuals receiving treatment, except those being treated in the ward.

4.6.6 Social Media

Current technology in various social media applications may be adopted as a means of communication and shall be in accordance with the social media policy.[53]

4.6.7 Notifications

Notification through telephone calls, Short Message Service (SMS) or other appropriate application for appointment and scheduling may be adopted.

4.7 PRIVATISED SERVICES

4.7.1 Security Services

a. Security services in the hospital or institution may be outsourced to a licensed security agency based on a contractual agreement and the scope of service shall be outlined in the contract.[54,55]

b. The appointed licensed security agency shall operate the security services, which shall be coordinated by the hospital or institution's General Administration Unit.

c. The security services shall encompass the following services;
   i. controlling the movement of authorised individuals within the hospital or institution premises;
   ii. ensuring the safety of hospital assets;
   iii. regulating vehicle traffic in compliance with traffic laws; and
   iv. ensuring the physical safety of staff, patients, and clients, including responding to risks, hazards, or disasters.

d. A security plan shall include standard operating procedures including the schedule for patrols, facility checks, visitor checks and a 24-hour security location.

e. The 24-hour security presence shall be determined by hospital or institution but generally covers at a minimum but not limited to the following areas;
   i. emergency department;
   ii. main entrance;
   iii. labour room;
   iv. maternity ward;
   v. Paediatric Ward including Neonatal Unit;
   vi. high dependency areas such as ICU, HDW, and CCU;
   vii. admission counter; and
   viii. logistic store.

f. The security system shall also include operational procedure in the event of special circumstances such as mass casualty, dignitaries' visits, evacuations, outbreaks, fire and these areas shall be demarcated by security staff.

g. The security plan shall cover the following items;
   i. safety of site of evacuation;
   ii. safety of building left unattended;
   iii. redirection of vehicle traffic;
   iv. control of crowd, press and victims and their belongings; and
   v. ensuring of access of authorised staff to location.

h. All security staff shall undergo police vetting and medical examinations to ensure their fitness for duty.

i. The security staff shall collaborate with law enforcement agencies and other relevant authorities.

j. As much as possible, appropriate technologies such as electronic access cards, security cameras, and automatic parking gates shall be employed.

4.7.2 Catering Services

a. The production and supply of diet shall be carried out in-house by the hospital or institution or the appointed outsourced food service company which shall be accountable to the Dietetic and Food Service of the respective hospital or institution.

b. All appointed food service companies shall be Halal certified.

c. Food preparation shall adhere to the Ministry of Health's Privatised Food Service Contract Specification.

d. Patients' diets shall be served using a fully centralised plating system.

e. Kitchen facilities and equipment which are government's assets shall be rented to the outsourced food service company.

f. The maintenance of government assets shall be carried out by the hospital or institution's concession company. Payments for the hospital or institution's utilities used by the outsourced company shall be made to the hospital or institution.

g. The Dietetic and Food Service Department shall ensure the following:

i. that raw and/or cooked food material received is of accepted standard and stored properly;
ii. scheduled samplings of raw and cooked food shall be collected at regular intervals and sent to the Public Health Laboratory for analysis;
iii. all food handlers shall be vaccinated and trained to ensure the provision of quality food; and
iv. all food preparations shall be in compliance with the MOH guidelines Hazard Analysis and Critical Control Points (HACCP).

4.7.3 Hospital Support Services

a. The following support services under HSS shall be outsourced to third-party service providers (concessionaires or contractors):
i. Facility Management Services (FMS);
ii. Facility Engineering Maintenance Services (FEMS);
iii. Biomedical Engineering Maintenance Services (BEMS);
iv. Cleansing Services (CLS);
v. Linen and Laundry Services (LLS);
vi. Healthcare Waste Management Services (HWMS); and
vii. HIS Operation, Support and Maintenance (OSM).

b. The services shall be delivered in compliance to the relevant acts, regulations and standards, and shall also be accordance with the requirements stipulated in the following documents:
i. Concession or Contract Agreement (CA)
ii. Master Agreed Procedures (MAP);
iii. Hospital Specific Implementation Plan (HSIP); and
iv. Project Operational Guidelines (POG) for each service and other related guidelines such as Manpower Norms Guidelines, Variation Management Guidelines, etc.

c. The service providers shall be registered with the Construction Industry Development Board (CIDB) as a facility contractor with F02 specialisation (healthcare facilities) under the Malaysian CIDB Act, 1994 [Act 520].

d. The Healthcare Facility Manager (HFM) shall be competent in healthcare facility management and registered with the CIDB and shall be responsible for planning and overseeing the HSS activities.

e. The contract agreement shall be governed by a committee, lead by the Hospital or Institutional Director and other appointed members to review performance, budgeting, discuss issues and identify areas for improvement.

f. A Validation Committee Meeting (VCM), chaired by the Hospital or Institutional Director, shall be held monthly involving engineering, liaison officers, and service providers to review and validate proposed deductions for non-conformance.

g. The engineering unit or department shall be responsible for the monitoring of the overall support services, verifying work completed, propose amount for deductions, manage technical issues and reporting the performance to the ministry.

h. For each outsourced service, a liaison officer shall be appointed to;
   i. oversee and coordinate with the service provider;
   ii. monitor the day-to-day operations;
   iii. coordinate all the activities; and
   iv. ensure compliance to the contract agreement and HSIP.

i. The HSIP is a dynamic document that shall;
   i. delineate the hospital's specific needs in compliance to the contract requirements;
   ii. be prepared annually, with amendments made as needed; and
   iii. be endorsed by the Hospital or Institutional Director.

4.7.3.1 Facility Management Services

a. FMS shall be led by a HFM who shall be responsible for the overall coordination of the services and shall focus on ensuring the overall functionality, comfort and safety of the hospital or institutes' built environment.

b. The responsibilities of HFM shall include the following;
   i. planning and overseeing facility operations;
   ii. ensuring compliance with contractual agreements and regulations;
   iii. managing emergency preparedness;
   iv. supervising maintenance and repairs;
   v. project and renovation management;
   vi. budget and resource management;
   vii. supporting patient and staff comfort; and
   viii. environmental sustainability initiatives.

c. All activities related to the services shall be recorded in the maintenance system and be accessible for review by the hospital or institution team.

d. Continuing improvement activities shall be planned and implemented within the hospitals or institution relating to FMS.

4.7.3.2 Facility Engineering Maintenance Services

a. Hospital or institution facilities including buildings, infrastructure, engineering plants and installations shall be operated in accordance with the designed specifications and operational requirements.

b. All activities conducted within FEMS shall comply with the relevant acts, regulations and standards and shall be carried out in alignment with the operational policies and guidelines.

c. Civil and structural facilities, mechanical and electrical engineering systems, plants, transportation and non-medical equipment shall be maintained through a comprehensive maintenance programme as outlined in the contractual agreement.

d. The comprehensive maintenance programme shall ensure that all facilities and systems in healthcare settings operate safely, efficiently, and reliably to support patient care and staff activities.

e. Backup systems shall be regularly tested and emergency protocols shall be established to ensure a swift response to utility failures during emergencies.

4.7.3.3 Biomedical Engineering Maintenance Services

a. All biomedical equipment shall be registered with the Medical Device Authority (MDA) in accordance with the Medical Device Act 2012 [Act 737].

b. All biomedical equipment shall be operated and function in accordance with the manufacturer's specifications or the intended purpose, based on the operational requirements.

c. All biomedical equipment shall be tested, maintained and calibrated according to manufacturer's manual to guarantee its availability, functionality and safety for both users and patients.

d. All activities conducted within the BEMS shall comply with the relevant acts, regulations and standards and shall be carried out accordance to contractual agreement in alignment with the operational policies and guidelines.

e. All activities related to the services shall be recorded in the maintenance system developed by the service provider and be accessible for review by the hospital or institution team.

4.7.3.4 Cleansing Services

a. The cleansing services shall aim to maintain a clean, hygienic, and safe environment throughout the hospital and shall follow a schedule outlined in the HSIP.

b. Correct techniques and equipment shall be used for cleansing activities and shall include the following;
   i. routine and deep cleaning;
   ii. infection control cleaning;
   iii. sanitisation and disinfection; and
   iv. environmental monitoring.

4.7.3.5 Linen and Laundry Services

a. The linen and laundry services shall ensure that all hospital linens are clean, sterilised, and readily available and the process shall be as the following;
   i. daily collection and sorting;
   ii. washing and drying;
   iii. ironing and folding; and
   iv. delivery and distribution according to the schedule.

b. Records of linen usage shall be kept accurately and tracking systems shall be implemented to monitor loss or wear-and-tear.

c. Regular quality checks shall be performed to ensure linens meet hygiene and safety standards, with replacement of linens as needed.

4.7.3.6 Healthcare Waste Management Services

a. The HWMS shall manage the safe handling, segregation, storage, transport, and disposal of hospital or institution waste in compliance with the health, safety and environmental regulations and the process shall include the following;[56,57]
   i. waste segregation into categories and daily collection;
   ii. temporary storage to prevent exposure or contamination;
   iii. on-site treatment and processing to render it non-hazardous before disposal; and
   iv. transportation and disposal.

b. All wastes shall be handled according to types and shall be in accordance to the standard precautions and infection control measures.[58,59,60]

c. Preparedness for managing accidental spills or leaks of hazardous waste, with protocols to protect hospital staff and patients shall be available.

d. Accurate records of waste volumes and disposal methods shall be maintained and shall comply with the regulatory standards.

4.7.3.7 HIS Operation, Support and Maintenance

a. OSM in HIS hospitals or institutions shall be maintained by IT Unit and system owner.

b. Monitoring of OSM activities by the vendor shall be performed by the IT Unit and the system owner as per contract.

c. Planning of consumables usage shall be done by the hospital or institution.

d. The hospital or institution shall plan for technology upgrades and infrastructure replacements as needed.

1 *Garis Panduan Mencegah dan Menangani Kekerasan Terhadap Warga Kerja di Fasiliti KKM, Edisi Kedua (2023).*
2 *Polisi Penyusuan Susu Ibu Kebangsaan.*
3 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 25, Tahun 2021 – Garis Panduan Perkhidmatan Sukarela di Fasiliti KKM, bertarikh 16 Disember 2021.*
4 *Buku Panduan Layanan Perkhidmatan Pelanggan (PLPP) Sektor Awam, Cetakan Kedua, 2023, Jabatan Perkhidmatan Awam.*
5 *Surat Edaran Ketua Setiausaha KKM – Arahan Menggunakan Tanda Larangan Penggunaan Telefon dan Tanda Larangan Membuat Rakaman Video dan Mengambil Gambar di Fasiliti Kementerian Kesihatan Malaysia, bertarikh 1 Mac 2017.*
6 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 4, Tahun 2006 – Larangan Penggunaan Telefon Bimbit dan Telefon Selular di Hospital-hospital dan Institusi-institusi KKM, bertarikh 28 Ogos 2006.*
7 *Audio and Visual Recordings Guideline of the Malaysian Medical Council MMC Guideline, 003/2023.*
8 *Surat Edaran Timbalan Ketua Pengarah Kesihatan (Perubatan) – Garis Panduan Mengenai Penggambaran Filem di Hospital-hospital Kementerian Kesihatan Malaysia oleh Pihak Luar (Produksi Media Kerajaan dan Swasta), bertarikh 28 Julai 2011.*
9 *Borang Keizinan Fotografi/Multimedia – PER/PHOTO/2016 (For clinical/educational purposes).*
10 *Peraturan Pegawai Awam (Kelakuan dan Tatatertib), 1993 [P.U.A 395/1993].*
11 *Laman sesawang MyPPSM Jabatan Perkhidmatan Awam – Urusan Perkhidmatan UP.7: Tatakelakuan & Pengurusan Tatatertib.*
12 *Surat Edaran Ketua Setiausaha KKM – Larangan Membuat Pernyataan Awam oleh Pegawai Awam di Kementerian Kesihatan Malaysia, bertarikh 22 Februari 2021.*
13 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 13, Tahun 2004 – Peraturan Membuat Kenyataan Kepada Media Massa Bercetak dan Elektronik serta Orang Ramai, bertarikh 5 November 2004.*
14 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 10, Tahun 2004 – Garis Panduan Mengenai Peraturan Lalu Lintas dan Meletak Kenderaan di Hospital-hospital KKM, bertarikh 24 September 2004.*
15 *Pekeliling Ketua Setiausaha Kementerian Kesejahteraan Bandar, Perumahan dan Kerajaan Tempatan, Bilangan 3, Tahun 2017 – Garis Panduan Perancangan Tempat Letak Kenderaan (TLK), bertarikh 10 Januari 2018.*
16 *Surat Edaran Bahagian Perkembangan Perubatan – Surat Pemberitahuan Mengenai Nama Persatuan Sukarelawan Hospital, bertarikh 13 Mac 2018.*
17 *Guidelines on Management of Medico Legal Complaints in Ministry of Health, Medical Practice Division, Ministry of Health Malaysia, 2019.*
18 *Garis Panduan Pengurusan Maklum Balas Awam, Versi 1/2020, Kementerian Kesihatan Malaysia.*
19 *Pekeliling Kemajuan Pertadbiran Awam, Bilangan 1, Tahun 2009 – Penambahbaikan Proses Pengurusan Aduan Awam, bertarikh 24 Februari 2009.*
20 *Akta Rahsia Rasmi, 1972.*
21 *Surat Pekeliling Ketua Setiausaha KKM, Bilangan 10, Tahun 2019 – Dasar Keselamatan ICT KKM Versi 5.0, bertarikh 19 September 2019.*
22 *Laman sesawang MyPPSM Jabatan Perkhidmatan Awam – Pentadbiran Organisasi PO.1 Pentadbiran dan Pengurusan Pejabat.*
23 *Tatacara Pengurusan Rekod Elektronik Dalam Digital, Document Management System (DDMS) di Pejabat Awam oleh Arkib Negara Malaysia, 2020.*
24 *Akta Arkib Negara, 2003 [Akta 629].*
25 *Panduan Pengurusan Rekod Sektor Awam 2016 oleh Arkib Negara Malaysia.*
26 *Pekeliling Perbendaharaan, Bilangan 5, Tahun 2007 - Tatacara Pengurusan Aset Alih Kerajaan (TPA).*

27 *Pekeliling Perbendaharaan Am 6.1 – Tatacara Pengurusan Stor Kerajaan (TPS).*
28 *Arahan Pentadbiran Ketua Pengarah MAMPU, Bilangan 6, Tahun 2014 – Panduan Pengurusan Mesyuarat dan Penulisan Minit Mesyuarat.*
29 *Pekeliling Transformasi Pentadbiran Awam, Bil. 2, Tahun 2018 – MyMesyuarat: Ekosistem Pengurusan Mesyuarat Era Digital.*
30 *Panduan Pelaksanaan Penyajian Hidangan Sihat Semasa Mesyuarat di Fasiliti Kementerian Kesihatan Malaysia (KKM) by Nutrition Division KKM.*
31 *Garis Panduan Pelaksanaan Sidang Video, Kementerian Kesihatan Malaysia.*
32 *Surat Pekeliling Am, Bilangan 3, Tahun 2022 – Garis Panduan Pengurusan Keselamatan Penggunaan Persidangan Video (Video Conferencing) dalam Perkhidmatan Awam, bertarikh 9 Disember 2022.*
33 *Surat Pekeliling Am, Bilangan 2, Tahun 2022 – Peraturan Menamakan Bangunan Kerajaan Persekutuan by Jabatan Perdana Menteri, bertarikh 30 September 2022.*
34 *Laman sesawang MyPPSM – Pentadbiran dan Pengurusan Pejabat PO.1.1.1 Pemerkasaan Penggunaan Bahasa Melayu Dalam Perkhidmatan Awam.*
35 *Arahan Perbendaharaan, Pindaan 2023.*
36 *Surat Pekeliling Ketua Setiausaha KKM, Bilangan 1, Tahun 2009 – Tatacara Pelaksanaan Projek ICT di Kementerian Kesihatan Malaysian (KKM), bertarikh 15 September 2009.*
37 *Surat Edaran Program Perubatan – Garis Panduan Tatacara Peminjaman Peralatan Perubatan Kepada Pesakit Bagi Meneruskan Rawatan di Rumah, bertarikh 25 Mei 2017.*
38 *Memo Bahagian Kewangan KKM – Garis Panduan Peminjaman Peralatan Perubatan Kepada Pesakit Bagi Rawatan di Rumah, bertarikh 26 Julai 2017.*
39 *Memo Bahagian Kewangan KKM – Permohonan Pengenaan Deposit Peminjaman Peralatan Perubatan Kepada Pesakit Bagi Meneruskan Rawatan di Rumah, bertarikh 30 Januari 2024.*
40 *Laman sesawang MyPPSM Jabatan Perkhidmatan Awam – Saraan.*
41 *Akta Acara Kewangan, 1957.*
42 *Surat Pekeliling Bahagian Kewangan, Bil. 2, Tahun 2012 – Pelaksanaan Pengecualian Caj Pendaftaran Jabatan Pesakit Luar Pakar Sebanyak RM5.00 dan Pengurangan Caj Sebanyak 50% bagi Pesakit Kelas 3 di Hospital/Klinik Kementerian Kesihatan Malaysia Kepada Semua Pesakit Warganegara yang berumur 60 tahun dan ke atas.*
43 *Surat Pekeliling Ketua Setiausaha KKM, Bilangan 2, Tahun 2019 – Garis Panduan Pelaksanaan Perintah Fi (Perubatan) (Kos Perkhidmatan) 2014, bertarikh 8 April 2019.*
44 *Surat Edaran Ketua Setiausaha KKM – Pelaksanaan Terimaan Bayaran Tanpa Tunai (Cashless) di Semua Fasiliti KKM Mulai Oktober 2022, bertarikh 21 Jun 2022.*
45 *Pekeliling Perbendaharaan PS 2.1 Terimaan Kerajaan Secara Elektronik (Tanpa Tunai), Pindaan Oktober 2024.*
46 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 17, Tahun 2012 – Penambahbaikan Garis Panduan Latihan Pemanduan Ambulan KKM, bertarikh 15 Mei 2012.*
47 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 7, Tahun 2019 – Pelaksanaan Policy on Safety of Land Ambulances, bertarikh 31 Disember 2019.*
48 *Pekeliling Perbendaharaan – Pengurusan Kenderaan Kerajaan.*
49 *Surat Edaran Ketua Setiausaha KKM – Garis Panduan Pemeriksaan, Penyelenggaraan dan Pembaikan Tayar Kenderaan Kementerian Kesihatan Malaysia, bertarikh 8 September 2020.*
50 *Surat Edaran Ketua Setiausaha KKM – Pematuhan Kelulusan Teknikal dan Pemantauan Projek ICT di Kementerian Kesihatan Malaysia, bertarikh 10 Januari 2024.*
51 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 13, Tahun 2011 – Dasar dan Garis Panduan User Access Control Policy (UACP) bagi Sistem Maklumat Hospital dan Klinik (HIS/CIS) KKM, bertarikh 13 Disember 2011.*

52 *Surat Edaran Bahagian Perkembangan Perubatan – Penyeragaman Kod Warna Kecemasan bagi Hospital dan Institusi Perubatan Kementerian Kesihatan Malaysia (KKM), bertarikh 18 Februari 2025.*

53 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 10, Tahun 2016 – Garis Panduan Penggunaan Media Sosial Dalam Perkhidmatan Penjagaan Pesakit di Fasiliti KKM, bertarikh 31 Mac 2016.*

54 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 14, Tahun 2002 – Garis Panduan Sistem Kawalan Keselamatan di Hospital-hospital KKM, bertarikh 20 November 2002.*

55 *Pekeliling Perbendaharaan Malaysia – Format Perjanjian Piawaian Perkhidmatan Kawalan Keselamatan.*

56 *Environmental Quality Act, 1974.*

57 *Environmental Quality (Schedule Waste) Regulations, 1989.*

58 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 6, Tahun 1994 – Garis Panduan untuk Membuang Alat-alat Suntik, Alat-alat Tajam dan Jarum yang Telah Digunakan di Hospital, Klinik dan Pusat Kesihatan di dalam Sektor Kerajaan dan Swasta, bertarikh 13 September 1994.*

59 *Guidelines on the Disposal of Chemical Wastes from Laboratories, 2015, by Department of Environment, Ministry of Natural Resources and Environment Malaysia.*

60 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 1, Tahun 1992 – Pengutipan Uri-uri yang Tidak Dituntut di Hospital-hospital KKM, bertarikh 22 Januari 1992.*

61 *Surat Edaran Timbalan Ketua Pengarah Kesihatan (Perubatan) – Etika Pemakaian Bagi Pelanggan di Fasiliti Kementerian Kesihatan Malaysia (KKM), bertarikh 25 Mac 2024.*

62 *Pekeliling Kemajuan Pentadbiran Awam, Bilangan 1, Tahun 2003 – Garis Panduan Mengenai Tatacara Penggunaan Internet dan Mel Elektronik di Agensi-agensi Kerajaan, bertarikh 28 November 2003.*

63 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 10, Tahun 2025 – Garis Panduan Tatacara Pengurusan Jenazah di Hospital dan Institusi Perubatan Khas KKM, bertarikh 21 April 2025.*

64 *Surat Edaran Ketua Setiausaha KKM – Tatacara Pelaksanaan Permohonan Kelulusan Teknikal dan Pemantauan Projek Teknologi Maklumat dan Komunikasi (ICT) Agensi Sektor Awam di Kementerian Kesihatan Malaysia, bertarikh 7 November 2024.*

CHAPTER

05 HOSPITAL GOVERNANCE


HOSPITAL
SULTANAH
HAJJAH KALSOM
CAMERON HIGHLANDS

05 Hospital Governance

5.1 APPOINTMENT AND SCHEDULING

a. All appointment may be made by physically or phone or other accepted medium depending on the availability of system in the hospitals or institutions.

b. Any service shall be given on an appointment basis except for the emergency and trauma services.

c. Any rescheduling for an early appointment shall be in accordance with the policy of the Department or Unit.

d. All clients shall be informed of the relevant documents to facilitate registration process such as the referral letter, appointment card, e-GL etc.

5.2 COUNTER SERVICE

a. All hospitals and institutions shall have a general information counter and other dedicated counters including the registration counters, clinic counters, ward counters etc. for the following purposes:

Providing Information

Providing Assistance

Receiving Suggestions or Complaints etc.

b. The counters shall be staffed by competent personnel with good public relations skills.

c. The senior staff shall supervise the effective delivery of related counters.

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

e. The Priority Lane or R-Lane at the registration counters may be provided to reduce waiting time and overcome crowding. The potential clients may include the following:

i. toddler aged one (1) year and below;
ii. senior citizen (60 years and above);
iii. blood donors (according to latest guidelines);
iv. disabled persons (*Orang Kelainan Upaya*);
v. persons in custody (*Orang Kena Tahan*) and inmates; and
vi. pregnant mother.

f For patients with safety concerns, such as individuals in custody, exposure to outside areas shall be limited, and the following practices may be implemented;[1]
   i. the hospital or institution may give appointments at non-peak hours, for example at the end of normal clinic hours or in the afternoon;
   ii. the authority for example the prison department shall inform the registration counter regarding the appointment of prisoners;
   iii. the hospitals or institutions shall prioritise and assist them in the consultation, examination and treatment at the Specialist Clinics, General Outpatient Departments and Emergency and Trauma Department; and
   iv. as far as possible, the individual in custody and escort officers shall be provided with separate waiting areas by the hospitals or institutions.

g The arrangement of patients with safety concerns shall be discussed and planned between the receiving hospital or institution and the referring agency.

h Digital kiosks shall be made available in the future for the purpose of self-registration, information retrieval and billing transactions.[2,3]

5.3 REGISTRATION

a Medical Record Number (MRN)
   i. MRN is a number generated through the system that shall specify the locality and number run in sequence;
   ii. the standard MRN shall consist of prefix hospital (maximum of 6 characters) with running number (total of 18 characters) e.g., HKLXXX123456789012;
   iii. all patients shall be given only one MRN for personal identification;
   iv. in all hospitals or institutions, patients shall be registered based on the document types that may comprise of MyKad, MyKid, passports (for foreigners), armed forces or police identification cards, UNHCR cards etc.; and
   v. the MRN shall be used in all forms or documents pertaining to patient care.

b All clients requiring registration shall present the relevant documents at the designated counters.

c Encounter Number (EN)
An EN number may be given to the patient by the system whenever patient/client encounters for clinical care at specialist clinic, emergency department, inpatient for admission, Day Care service or any ancillary support service e.g., physiotherapy, counselling clinic and screening clinic.

d The function of online registration shall be made available when the need arises.

e There are two (2) types of registration which shall be as the following:
   i. **general registration** for general or daily circumstances of operations; and
   ii. **specific registration** for specific purposes.

5.3.1 General Registration

	Type of Patients	Action
a	Adults	All adult patients shall be registered.
	Children	Children below the age of 12 shall be registered using their MyKid or any other relevant documents.
	Newborn	i. The identification of newborn shall use mother's identification card or passport or other ID plus prefix "E" or "M" followed by sequence of delivery e.g second baby born to a mother with MyKad: 90081717XXXX shall be identified as 90081717XXXX E02 or 90081717XXXX M02; ii. All newborns shall be registered and MRN shall be given; iii. All stillbirths (fresh or macerated) shall be registered for clinical or reporting or costing (casemix) reasons and MRN shall be given; iv. No EN shall be given to stillbirths; and v. For any ill babies requiring admission, EN shall be given.
	Birth Before Arrival (BBA)	BBA or birth in ambulance or other vehicles. i. The transporting ambulance shall reroute to the nearest health facility and registration shall be done at the facility (government or private) ii. If the umbilical cord is cut by any hospital staff, it shall be taken into consideration as a hospital birth; and iii. In Health Information Management System (HIMS) Statistics (PER PD 102), location of this birth is considered BBA and the name and identification card number of the attending staff shall be recorded.
	Patient in the ETD	All cases in the ETD shall be stabilised prior to admission to the ward and in circumstances whereby the patient is already registered at the registration counter but deteriorates during the journey to the ward, the following two (2) scenarios may be considered; i. if the patient is still near the vicinity of the ETD, the patient shall return to the ETD and if death occurs, it shall be an ETD statistical death and the admission shall be cancelled in the system with justification; and ii. if the patient is nearer to the ward, the patient shall be wheeled to the ward, and it shall be the ward statistic death if the patient succumbs.

b The registration format shall be as specified by the relevant guideline and the staff at the registration counter shall be responsible for ensuring the completeness of the information.

c For cases using fake or false identification, once known, the hospital or institution staff shall report to the relevant authority or police and inform the MRO and a new MRN shall be created for that patient.

d All data under fake or false identification after verification by the MRO shall be migrated to the new MRN.

e The fake or false identity name and data shall be deleted totally after data migration.

f For multiple registrations using different document types, all data shall be unified under one (1) MRN after verification by the MRO or Hospital ICT Committee and Champion.

g Upon registration at the *Bilik Daftar Masuk* (BDM) or *Kaunter Pendaftaran Masuk Wad*, the patient shall be assigned to a bed based on availability.

5.3.2 Specific Registration

	Type	Format
a	Disaster Registration	i. A standard operating procedure (SOP) shall be in place at every hospital or institution, which shall include Pre-Registration SOP at the site of disaster, if relevant.
		ii. The Disaster Registration Format shall be as the following: Hospital prefix + D (Denote for Disaster Registration) + date (ddmmyy) + disaster case identification + running number or any automated ID generated by HIS/EMR system e.g.: HTJXXX D 050621 A 0001.
b	Quick Registration	i. Quick registration is developed specifically for dire emergencies in the ETD and Patient Assessment Center (PAC).
		ii. The Quick registration format shall be as the following: Hospital prefix + Q (Denote for Quick Registration) + date (ddmmyy) + running number or any automated ID generated by HIS/EMR system e.g.: HTJXXX Q 080721 00007.
c	Unknown Registration	i. Patients with unknown identities shall be registered as 'Unknown' and updated immediately when information is obtained by the staff.
		ii. The format of the temporary registration shall be as the following: Hospital prefix + U (Denote for Unknown Registration) + date (ddmmyy) + running number e.g.: HTJXXX U 080721 00007.
d	Temporary Registration for Teleconsultation (TC) Cases	i. In secondary and tertiary facilities, specialist and/or medical officers may receive consultation or referral via phone call or other communication methods. A temporary registration shall be made by the recipient facility.
		ii. The format of the temporary registration shall be: Hospital prefix + TC (Denote for Teleconsultation) + date (ddmmyy) + running number e.g.: HTJXXX TC 080721 00007.
e	Registration of patient without person	i. In this situation, there shall be registration and encounter without the actual person for specific purposes at the discretion of the Hospital or Institution Director.
		ii. The format of the registration shall be as the following: Hospital prefix + V (Denote for Patient without Person) + date (ddmmyy) + running number e.g.: HTJXXX V 080721 00007.
f	Registration of external patients for investigation and procedures	i. For the purpose of investigation or procedures ordered at the other healthcare facilities, this function shall be made available in the system.
		ii. The format of registration shall be as the following: Hospital prefix + EXT (Denote for External Patient) + date (ddmmyy) + running number or any automated ID generated by HIS/EMR system e.g.: HTJXXX EXT 080721 00007.

	Type	Format
g	Registration During or After Downtime	i. Each healthcare facility shall follow its own Business Continuity Plan (BCP).
		ii. During system downtime, the healthcare facility may use the manual pre-printed forms for registration purposes.
		iii. After downtime, all manual registrations shall be keyed-in into the system.
h	Online registration	i. For the registered patients, online registration shall be made available in the future whereby the patients shall be able to register themselves for the particular appointment day.
		ii. For the unregistered clients, they may request for an appointment slot online, subject to the acceptance and discretion by the particular clinic.
i	Registration of external samples without person	i. This function shall be made available in the LIS system and RIS system.
		ii. In the HIS, this function shall be made available if the system can be used modularly for LIS and RIS.
j	Cluster registration	The registration in cluster hospitals or institutions shall have a unique cluster identifier for each cluster according to the cluster policy.

For cases in item a, b and c above, the registration process shall be updated within 24 hours. If information of an unknown patient is not available after 24 hours, a police report shall be made.

5.4 HOSPITAL AND MEDICAL FACILITIES

5.4.1 Specialist Clinics

a. The clinics shall be used to provide specialist outpatient care. All specialist clinics shall operate under the supervision of the specialist in charge.[4]

b. The consultation and examination rooms shall be commonly shared between the various departments or units as and when necessary. Patient's privacy shall be maintained throughout the consultation based on a predetermined clinic schedule.

c. Attendances to specialist outpatient clinics are by referral and appointment. The respective department shall determine the clinic schedule, the appointment system and patient management at the clinic.

d. The appointment and scheduling system shall be determined by the respective hospital or department or unit (manual or computerised).

e. All appointments are given based on the availability of resources. For urgent appointments, the referring doctor shall be required to consult the specialist or medical officer of the respective discipline before referring the patient.

f. Rescheduling or cancellation and deferral of appointments shall be approved in accordance with the policy of the department or units approved by the hospital or institution management.

g. All patients requiring an appointment shall produce the relevant document to facilitate appointment scheduling and registration such as the referral letter, appointment card, guarantee letter (e-GL) etc.

h. The Queue Management System (QMS) in all clinics shall be part of or integrated to HIS.

i The necessary fees related to the services provided shall be paid by the patient according to the Fees (Medical) Order and its amendments/revised circulars and a receipt shall be issued.

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

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

5.4.2 Emergency and Trauma Department

a The hospital or institution shall provide prehospital and hospital emergency services on 24-hour basis. The department shall be responsible for the provision of emergency care to patients to save lives, preserve body functions and prevent complications. The services shall be under the responsibility and supervision of the Head of ETD.[5,6,7]

b The hospital or institution shall ensure the availability of ambulances that are equipped with trained staff to provide prehospital care service.[8,9,10]

c The hospital or institution shall establish a communication coordinating centre to coordinate emergency responses and ensure effective communication and collaboration between healthcare providers, Emergency Medicine and Trauma Medicine (EMTS) and relevant stakeholders.

d The hospital or institution shall have a coordinated system in place to facilitate the intra-facility and inter-facility transfer of patients.[11]

e The hospital or institution shall have a triage system in place to prioritise patients based on the severity of their condition. The triage system shall be staffed by trained personnel who can rapidly and efficiently assess patients and assign them to appropriate treatment areas.[12]

f The department shall have designated areas or zones for management of patients according to the severity of illness including isolation areas for infectious disease cases.

g The hospital or institution shall have adequate resources and equipment to provide high quality emergency and trauma care, including equipment for life saving procedures, point of care tests, diagnostic equipment and medications.[13,14]

h The hospital or institution shall provide observational medicine services to provide care for patients who require further evaluation but do not need admission to the hospital or institution.

i The hospital or institution shall have a One Stop Crisis Centre (OSCC) service to provide medical, legal and psychosocial support for victims of violence, abuse or neglect.[15]

j The hospital or institution shall have adequate and appropriate disaster management plans in place that includes protocols for responding to internal and external emergencies, such as natural disasters or mass casualty incidents.[16,17]

k Suitable medical coverage standby team shall be coordinated for mass gathering or major event based on the risk assessment conducted.[18]

5.4.3 Day Care

a. Day care services are the clinical services that are provided by which suitable patients are managed with admission, procedure and discharge on the same day.

b. The day care procedures shall include diagnostic and therapeutic procedures that are low risk and identified suitable according to patient selection criteria as outlined in the daycare service policy.[19,20,21]

c. The day care services may be provided either at a facility designated for day care such as ambulatory care centre (ACC) or at any other facility in the hospital or institution and the categorisation of day care infrastructure shall be outlined in the current policy or SOP.

d. The basic components for day care services, which may be shared, shall include patient registration or payment counter, waiting area, procedure room, observation area which shall include appropriate and adequate numbers of day care beds or chairs or both, assessment clinic, counselling room and pharmacy.

e. An appointment and advance order shall be made prior to the day care encounter for all day care patients. Advance orders shall be made from the previous admission or previous clinic encounters manually or in the HIS.

f. Registration of patients for the day care services shall follow the standard registration process in the hospital or institution.

g. Consent shall be obtained by the attending doctor prior to the day care procedure.

h. Patients shall be certified fit by a medical officer before discharge and if they are deemed unfit, they shall be admitted for further management.

5.4.4 Operation Theatre

a. The hospital or institution management shall be responsible for providing operating theatre (OT) services to cater for elective as well as emergency procedures involving general, regional and local anaesthesia.[22]

b. An OT Committee shall be established to govern the operating theatre services.

Members of OT Committee shall consist of the following:

i. Hospital Administrator;
ii. Clinicians e.g., Surgeons, Anaesthesiologists;
iii. Nursing and AMO administrators; and
iv. relevant supporting service.

c. OT Operating Hours

i. As far as possible, all elective surgeries shall be carried out between 8.00 AM to 5.00 PM or until the last case is completed, on normal working days according to schedule by the respective departments based on the allocated OT days.
ii. Additional elective OT shall be carried out on weekends with the approval from the MOH to reduce waiting time depending on the need and availability of resources.[23]

d. An emergency OT shall be operational 24 hours a day and when required, an additional Emergency OT shall be open.

e All patients undergoing elective and emergency surgery shall be assessed by the anaesthetic Medical Officer and/or Specialist.

f All operative procedures performed shall be documented in the patient's record or entered into the Operation Theatre Management System (OTMS) or HIS for integrated care, reporting and analytical purposes.

5.4.5 Intensive Care

a Any patient, especially adults, admitted to the Intensive Care shall be cared for by the intensive care team from the Department of Anaesthesiology and Intensive Care along with the primary department or unit.[24,25]

b The admission and discharge of all patients to and from ICU shall be determined by the intensivist or anaesthesiologist-in-charge in consultation with the respective specialist from the referring department or unit.

c Priority for admission;
i. priority for admission shall be guided on the urgency of the patient's need for intensive care and admission criteria.
ii. unscheduled or emergency admission shall take precedence over scheduled elective surgical admission.
iii. triaging of admissions to the unit shall be done by the intensivist or anaesthetist.

d Withholding or withdrawal of therapy and end-of-life care;
i. when continuing intensive care is deemed medically futile, withholding or withdrawal of therapy shall be considered following consensus with the primary unit.
ii. this decision on end-of-life care shall then be discussed with the family.
iii. if a patient is brain dead, referral to the Organ Procurement Team shall be initiated.

e Discharge Against Medical Advice (DAMA);
i. in cases where relatives or next of kin requesting DAMA for ill ventilated patients to be transferred to other medical facilities, the specialists shall discuss and provide adequate explanation including the risks involved prior to approval for DAMA.
ii. pre-transfer communication between the specialists of the referring and receiving unit or facility shall be done.

f For referral to a private facility on a patient's request, the arrangement for the transport and care during the transfer shall be the responsibility of the relative or next of kin.

g The clinical management of patients in the intensive care units shall be guided by the relevant guidelines.[66]

h Specific infection control measures shall adhere to related guidelines.[26]

i 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.

j As far as possible, the number of intensive care unit beds shall be at least 3-5% of the total acute hospital beds in Type 1 and Type 2 hospitals or institutions.

5.4.6 Mortuary Services

a. Mortuary services shall be made available in all MOH hospitals and selected institutions.

b. If there is no resident Forensic Medicine Specialist, the mortuary services shall be under the responsibility of a Resident Medical Officer appointed by the Hospital or Institution Director.

c. The services shall include but not limited to provision of body reception, body storage, body preparation area, area for viewing and bereavement and autopsy suite (where applicable).[27]

d. Appropriate transport to transfer the cadaver to the mortuary shall be provided where the dignity of the patient shall be preserved.

e. Complete records either manual or any electronic record such as the Forensic Management Information System (FMIS) shall be maintained and may include the following;
   i. registration of bodies received;
   ii. records of specimens forwarded to laboratories;
   iii. all specimens and evidences taken from deceased or patients; and
   iv. all relevant reports are filed with records of the deceased.

f. When post-mortem is required, the policies and procedures relating to medicolegal post-mortem examination shall be clear, accessible and understood by the staff such as;
   i. the persons who are authorised to order post mortem examination; and
   ii. proper handling of specimens as required by law;
   to ensure that the chain of evidence shall be maintained throughout the process of specimen handling.

g. There shall be safety and quality improvement activities in place which may include timeliness on releasing bodies to next of kin or claimant and timeliness on performing autopsies.

5.4.7 Laboratory Services

a. The laboratory services in MOH hospitals or institutions shall be performed in Pathology laboratories.

b. The basic and specialised services shall be provided in the hospital laboratories according to the category of hospital or institution as administratively classified by the MOH.

c. The basic and specialised services shall be organised and administered to provide a comprehensive and quality diagnostic service for quality and safe patient care.

d. The Pathology Department shall be responsible to provide a current Laboratory User Manual and documented Standard Operating Procedures Manual available for staff reference as a guide for specimen collection, handling and transportation to the laboratory.

e. Request for tests;
   i. tests shall only be requested by a registered medical and dental practitioner involved in patient management;
   ii. the request shall be made in the specified laboratory form, or electronically into the computerised order entry (COE) in the integrated HIS or Laboratory Information System (LIS) where available; and
   iii. verbal requests for additional tests shall be discouraged.

f. A system shall be in place to ensure all relevant tests are validated by competent persons.

g. Automation;
   i. automation shall replace manual methods where available;
   ii. important steps of specimen movement or process shall be entered or captured in the HIS or LIS; and
   iii. automatic flow of information to or from analyser machines shall be feasible in an integrated HIS.

h Collection and transportation of samples;
i. the specimen collection shall follow the guidelines provided by the Pathology Department;
ii. whenever possible, automated sample delivery which shall include via pneumatic tube, shall be made available; and
iii. the Pathology Department shall be responsible to monitor the transportation condition of the samples to the laboratory to ensure quality of test results is maintained.

i Test result or report;
i. the clinical interpretation of test result or report shall only be made by clinically qualified personnel namely the trained MO or Pathologist;
ii. the laboratory shall notify the ward or clinic of test results exceeding "critical values" that are established at the national level or hospital and institutional level; and
iii. all URGENT tests shall be given immediate attention and results to be informed within the Turnaround Time (TAT) established at the national Level or hospital and institutional level.

j Point of care testing (POCT) may be allowed for tests that are required for immediate patient management.

k The POCT services shall be coordinated by the POCT committee at all levels and in consultation with the pathologist or in the absence of a resident pathologist, the science officer in charge.

l The laboratory safety practices shall comply with the existing laboratory safety requirements and all relevant statutory acts and regulations.

m All laboratory staff shall be given adequate training in laboratory safety.

n As much as possible, all laboratory Services shall be accredited to MS ISO15189, a standard for medical laboratories compliance to the requirements for quality and competence.

o All laboratories shall also participate in the External Quality Assurance (EQA) programme either provided by the national reference centres or internationally recognised EQA providers, to ensure the quality of tests provided and for patient safety.[28]

5.4.8 Radiology Services

a All radiology procedures shall be performed by qualified and credentialed personnel.

b Notwithstanding the above, medical personnel who have undergone appropriate training in specific procedures may be privileged to perform the procedures.

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

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

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

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

g Any examination on a patient shall be carried out in the presence of an appropriate chaperone.

h For all radiological examinations involving ionizing radiation, the dose or exposure factors or fluoroscopy time shall be recorded.[29]

5.4.9 Pharmacy

Value Added Services (VAS) shall be implemented, such as the following:[30]

a	 **Drive-Through Pharmacy**	Any patient who wishes to collect their monthly prescription refill through the drive-through pharmacy counter may register as such with the Outpatient Pharmacy, subject to the guidelines and criteria set out by the Pharmaceutical Services Division, MOH.
b	 **Drug Delivery by Post (*Ubat Melalui Pos*, UMP)**	Any patient who wishes to collect their monthly prescription refill via UMP may register as such with the Outpatient Pharmacy, subject to the guidelines and criteria set out by the Pharmaceutical Services Programme, MOH.
c	 **Locker4U**	Dispensing system where patients can use the L4U appointment card to notify for obtaining follow-up medication supplies at the pharmacy counter.
d	 **SPUB (*Sistem Pendispensan Ubat Bersepadu*)**	Any patient who wishes to collect their monthly prescription refill at a different MOH facility may be considered and referred as such via the SPUB.

For the VAS in items (a), (b), and (c) above, patients may apply through the MyUbat application.

5.4.10 Staff Facilities

a. Staff facilities may be allocated either to individuals, such as office rooms and rooms in the nurse hostel, or shared by all staff, such as restrooms and staff changing rooms.

b. Common areas shall fall under the responsibility of either the General Administration or the specific department where they are located.

c. Oncall rooms shall be provided for doctors oncall.

d. Accommodations or quarters may be provided to certain staff based on service needs, availability, and eligibility.

e. Sports facilities, where applicable, may be provided for recreational purposes for staff.

5.5 BOARD OF VISITORS

5.5.1 Hospital or Institution Board of Visitors

a. All hospitals or selected institution shall establish a Board of Visitors according to the MOH guidelines established by *Bahagian Khidmat Pengurusan,* with members appointed by the Minister of Health.[31,32,67]

b. The Board of Visitors shall serve as a vital link between the hospital or institution and the community, facilitating communication and feedback.

c. The Board members shall be permitted to visit wards and public areas, accompanied by the management staff during or after office hours.

d. Feedback and issues raised by the Board shall duly addressed by the management.

5.5.2 Psychiatric Hospitals or Institutions Board of Visitors

a. All psychiatric hospitals or institutions shall be required to appoint a Board of Visitors as stipulated in the Mental Health Act 2001.

b. The Minister of Health shall appoint members of the Board of Visitors, numbering up to 25, based on the psychiatric bed capacity and admissions.

c. The Board composition shall include at least three (3) registered medical practitioners, which shall preferably include a female psychiatrist not affiliated with the psychiatric hospital or institution, and shall have a minimum of three (3) female members overall.[33,34]

5.5.3 Medical Board

a. All Medical Board establishment applications shall be submitted through the State Health Office or *Hospital Kuala Lumpur* (HKL) or *Yayasan Perubatan Persekutuan*.[35]

b. An application with the purpose of termination of an officer due to medical reasons shall be in the *Lampiran PP.1.2.4(A)* and submitted with the required documents.

c. Any application for other circumstances than those stipulated in the *Garis Panduan Penubuhan Lembaga Perubatan* shall be sent in writing according to the reasons.

d. Composition and conduct of the Medical Board;
   i. the Medical Board panel shall consist of at least two (2) specialists including a specialist in the related discipline and shall be chaired by the Hospital or Institution Director or Deputy Director (Medical) or Head of Department appointed by the Hospital Director;
   ii. any medical officer or specialist involved in treating the patient shall not be appointed as one (1) of the Medical Board members; and
   iii. the patient shall be present during the meeting but in some circumstances, the Board may exempt the patient from being present.

e. The Medical Board report shall use the format as stipulated in the guideline.[35]

f. Report;
   i. the report shall be prepared in three (3) copies with two (2) copies to be sent to the State Health Office or HKL or *Yayasan Perubatan Persekutuan* and one (1) copy to be kept in the respective hospital; and
   ii. the report shall be ready within six (6) months from the date the completed application form was submitted.

g. The application for the Medical Board shall be charged in accordance with the Fees (Medical) Order 1982 or its amendments.

5.6 SPECIAL INITIATIVE

5.6.1 Cluster Hospitals

a. Cluster Hospital shall be defined as a grouping of hospitals or institutions by geographical location within a state, where the hospitals or institutions shall be aligned in terms of patient flow and services.

b. It aims to extend specialist services to district areas, alleviate congestion, ensure continuity of specialist treatment, and optimise resource utilisation.

c. The cluster hospitals share facilities and resources, including manpower and equipment, and shall operate efficiently to deliver care to the population.

d. They shall provide a range of secondary and tertiary services with networks and linkages for seamless delivery of care and follow up, integrating with the primary care services in the area.

e. In delivering services, Cluster Hospitals shall ensure that administrative and management functions are synchronised to facilitate integrated and coordinated clinical service delivery, ultimately achieving quality, safe, and efficient outcomes.

f. Cluster Management Committee (CMC) shall manage the operation and performance of the cluster.[36,37]

g. It shall be responsible and accountable for the provision of the day-to-day services in the cluster.

h. The Hospital or Institution Director of the Lead Hospital shall be the chairperson of the CMC.

i. The Governing Body (GB) shall be established at the state level, chaired by the State Health Director.

j. The GB shall be responsible for the overall performance of the Cluster Hospitals in the state; therefore, it shall provide stewardship and ensure effective governance of Cluster Hospitals.

k. Cluster Hospitals shall be required to adhere to all policies concerning patient care, capital development, financial control, and legal matters.

l. Services provided under the cluster shall comply with legal requirements and standards set by the MOH for quality, client charters, performance, efficiency, facilities (e.g., accreditation), and others.

5.6.2 Full Paying Patient Services

a. The Full Paying Patient (FPP) Services represent a service available at certain MOH hospitals or institutions.

b. Any patient who have the means to pay or insured may opt to receive treatment from eligible specialists, under the FPP services.

c. They shall be charged the full cost without government subsidies for their medical treatment and services.

d. This service forms part of a retention package for government specialists, allowing them to earn supplemental income while maintaining their service in public hospitals or institutions to cater to the needs of the general public.[38]

5.6.3 *Hospital Mesra Ibadah*

a The *Hospital Mesra Ibadah* (HMI) has been implemented since 2014 through a collaborative effort between the MOH and the Department of Islamic Development Malaysia (JAKIM).

b This program is designed to;
i. address the spiritual needs of patients and their families through education during their hospitalisation and treatment;
ii. create an *ibadah*-friendly environment within the hospital or institution; and
iii. educate and improve staff knowledge and skills in dealing with issues related to patients' and their families' Islamic beliefs and practices *(ibadah)*.[39]

5.6.4 *Sekolah Dalam Hospital*

a *Sekolah Dalam Hospital* (SDH) is a collaborative effort between the Ministry of Education (MOE) and the MOH to address the issue of school dropouts among children and secondary school adolescents during hospitalization.

b The expansion of this programme shall be initiated through hospital applications.[65]

c The patient selection criteria for the SDH programme shall include the following;
i. Malaysian citizen students enrolled in primary or secondary government or government-aided schools;
ii. Students who are expected to undergo treatment in the hospital for at least three (3) days;
iii. Students who are clinically, physically, and mentally fit to learn, as certified by a medical officer.

5.6.5 External Assignments

a Any registered medical practitioner or dental practitioner registered with the Malaysian Medical Council (MMC) or Malaysian Dental Council (MDC) respectively, may engage in external assignments (locum) at any designated private and government clinics and hospitals or institutions on a part-time basis, subject to approval from the Head of Department.[17,40,41,42]

b The locum place shall need to be registered in the Annual Practicing Certificate (APC) and if the place of practice is private, he or she needs medical indemnity coverage.

5.6.6 Flexi Working Hours

a Any specialist at UD54 (SSPA UD14) grade and above, meeting the specified criteria shall be permitted to adopt flexible working hours, enabling them to engage in activities within MOH facilities or work within the private sector.[43]

b The process for seeking approval shall follow the specific guidelines outlined for such requests.

c For any female staff who are five (5) months pregnant and above, there shall also be permission for early release, one (1) hour from the usual working hours.[44]

d This permission shall also be extended to husbands who are Public Service Officers and work in nearby locations to facilitate the wife who is pregnant for transportation.

e During Ramadan, the hospital or institution staff who are eligible, may opt for *Kemudahan Waktu Bekerja Berperingkat bulan Ramadan* (Ramadan WBB).

5.6.7 Casemix and Diagnosis-Related Group

a The Casemix system, and Diagnosis-Related Group (DRG), is a strategic hospital management tool designed to enhance healthcare delivery through effective resource allocation and cost efficiency. It supports value-based, data-driven decision-making across various levels of hospital operations.

b Casemix shall play a critical role in classifying patient cases by clinical complexity, enabling systematic disease distribution management, quality monitoring, and financial oversight.

c By implementing the Casemix system, hospitals shall be empowered to strengthen healthcare planning, enhance service efficiency, and support ongoing health financing reforms.

d The Casemix application shall be able to help the top management of the MOH in;

i. planning the development of health service delivery more accurately and efficiently;
ii. estimating expenditure allocation for the national health services required by the MOH based on actual output-based services delivered; and
iii. guiding the MOH towards the transformation of the National Healthcare System.

5.6.8 Lean Initiative

a The Lean Healthcare Initiatives is a philosophy that seeks to eliminate waste in all aspects of organisational activities such as human relations, inter-departmental relations, technology and the management of materials.

b Lean concept includes principles, methods and tools that shall be used to improve process efficiency by removing wasteful steps in the hospital or institution.[45]

5.6.9 Bed Management Unit

a A Bed Management Unit (BMU) shall be established to coordinate beds in the hospital or institution to help reduce congestion and patients' waiting time for beds through a more dynamic and efficient bed management, including admission, discharge and transfer processes.

b The BMU shall be under the purview of the Hospital or Institution Director or any person authorised by the Director.[46]

5.6.10 Traditional & Complementary Medicine

a The establishment of Traditional & Complementary Medicine (T&CM) units in MOH hospitals or institutions shall follow the existing guideline.[47,48]

b The T&CM services shall include but not limited to Malay Massage, Acupuncture, Herbal Therapy as Adjunct Treatment for cancer, Shirodhara, External Basti Therapy and Varmam Therapy.

c The T&CM Unit shall be headed by a Registered Medical Practitioner (RMP), or a Registered Pharmacist in the absence of a RMP.

d The Head of T&CM Unit shall oversee the provision of T&CM services in the unit and shall also be responsible for the management and operation of the unit under the support of the T&CM Unit Staff.

e Attendance to the T&CM Unit shall be facilitated through a two-way communication mechanism for both new and follow-up cases, as completed by the Registered Medical Practitioners (RMPs) from the primary care team.

5.7 MANAGEMENT OF RECORD AND REPORTS

5.7.1 Medical Records

a. Every patient receiving care in the hospital or institution shall have an individual medical record either physical or electronic medical record (EMR).

b. All treatments given and procedures performed shall be documented in the patient's medical record or EMR and shall be compiled as one medical record.

c. The attending medical practitioner shall be responsible for the proper documentation and legibility of the notes in the patient's medical record or EMR.

d. Any hospital using the manual system shall implement an integrated case note which shall be as the following;[49,50]
   i. all these forms and documents shall be arranged in an orderly manner in the medical records;
   ii. the arrangement shall be in accordance with the admission episode or visit where the most recent treatment episode shall be placed at the top;
   iii. all referral letters and other documents related to the care shall be kept together with the patient's medical record; and
   iv. a system shall be established to facilitate fast retrieval of medical records.

e. In the HIS hospitals or institutions;
   i. all healthcare providers shall enter the patient's progress into the system based on their login ID;
   ii. all end users of the HIS system shall abide by the User Access Control Policy (UACP); and
   iii. limited physical documents may still be available in the HIS hospitals or institutions including the referral letters, consent forms, ECG etc.

f. The management of the medical records shall be under the responsibility of the Medical Record Department or Unit.

g. However, in general, the security of the patient's medical records and EMR shall be under the responsibility of the Hospital or Institution Director.

h. The patient's medical record shall not be handed over to any party except with the written approval of the Hospital or Institution Director.

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

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

5.7.2 Medical Records Disposal

a. The patient's medical records shall be kept for a set period of time to meet the needs of treatment, legislation, research etc. and shall be in accordance with the latest disposal schedule prepared by the MOH.[51]

b. The medical records officer or the officer in charge of managing medical records at the hospital or institution shall be responsible for ensuring the compliance with the existing guideline.

5.7.3 Medical Reports

a. The medical reports shall be prepared upon receiving the written requests from the patient or any authorised person.[52]

b. Upon receiving the written requests, the report shall be prepared with reference to the content in the patient's medical record.

c. The medical reports shall be prepared;
   i. by the medical officer or specialist in the respective discipline involved in the patient care; and
   ii. within a specified time as stipulated in the latest guideline.

d. A medical report that has been officially released shall not be altered or tampered.

e. When there is suspicion of tampering of the medical report;
   i. any party including the patient, lawyers or insurance company may request for verification; and
   ii. the hospital or institution shall verify that it is 'similar' or 'not similar' to the original report released by the hospital or institution.

f. The medical reports of medicolegal or potential medicolegal cases shall be prepared by the medical officer or specialist managing the case and shall be verified by the head of the department before release.

g. The medical reports shall be charged in accordance with the Fees (Medical) Order 1982 or its amendment and shall be in accordance to the Ministry's circulars.

5.7.4 Medical Statistics

a. All data and statistics to be collected shall be as specified by the Ministry or the Medical Record Committee of the hospital or institution.[49]

b. The respective department and unit shall verify the statistics or reports prior to submission to the medical record unit within the specified time.

c. Any request for medical data and statistics of the hospital or institution shall be made through the Medical Records Department or Unit, and its release shall be subject to the approval of the Hospital or Institution Director.

5.8 CLINICAL CARE DOCUMENTATION

5.8.1 Manual Documentation

a. The clinical management of all patients shall be recorded and documented in the outpatient card, case notes, or computerised system, and shall be updated upon completion of the examination by the attending staff involved in the patient's treatment episode.[49]

b. All documents related to patient management, including laboratory results, X-rays, nursing care plans, observation charts, etc., shall be compiled with the case notes and kept up to date.

c. The documentation of clinical care shall be maintained by the staff attending to the patient and each entry, where appropriate, shall be dated, initialled and stamped mannually or using the computerised system.

d All amendments made shall be clearly cancelled and initialled by the respective staff.

e All entries shall not be deleted by any method of correction.

f All patients' medical records shall be sent to the Medical Records Department or Unit within 72 hours after discharge.

5.8.2 Electronic Medical Record

a Electronic Medical Record (EMR) is created in a healthcare facility that operates using the HIS.

b All patients' care shall be entered and stored in the EMR.

c All patients shall be required to be registered at the registration counter through the system and a MRN will be generated.

d All new patients registering for the first time shall be given a MRN which shall be used for every hospital admission.

e The new data entry is best to be keyed–in by a healthcare provider or automated flowed-in from other systems or applications.

f The cut and paste function as a new data entry shall be made possible upon the following condition;
i. the original source of information is mentioned;
ii. the original author is named; and
iii. the date and time of copy-and-paste's activity is stamped.

g All information in the EMR shall be confidential and shall not be printed, copied, recorded and disseminated to any unrelated party except with the permission of the Hospital or Institution Director or Court order through the Medical Records Department or Unit.

h All supporting systems such as Laboratory Information System (LIS), Radiology Information System (RIS) and Picture Archiving and Communication System (PACS), Critical Care Information System (CCIS), Oncology Information System (OIS), Nuclear Medicine Information System (NMIS), Medical Programme Information System (MPIS), Operation Theatre Information System (OTMS) etc. shall be integrated to the main HIS.

i EMR shall always be accessible in the system and shall be in accordance with the User Access Control Policy (UACP).

j The custodian to the EMR shall be the Medical Record Department or Unit but the access control of the EMR shall be under purview of the Information Technolgy (IT) Unit who shall be the IT Administrator.

k For users who have been inactive for more than three (3) months, access to the system shall be denied by the IT Unit upon notification by the relevant department or unit.

5.8.3 Summaries in EMR

There shall be two (2) types of summaries depending on the services rendered, which shall include the **encounter summary** and **discharge summary**.[53,54]

Encounter Summary (ES)

i. ES is defined as a summary made at the end of every encounter by the Healthcare Personnel (HCP) in outpatient set-up and day care services;
ii. the ES may be made available in the HIS/EMR;.
iii. the ES shall be prepared once the patient has completed seeing the HCP such as in the Emergency Department, Day Care Unit, Specialist Clinic, Rehabilitative Clinic, Diet Clinic and etc.;
iv. the ES is auto generated once the HCP dismisses the client for the event.;
v. the defined content shall be auto populated in the ES;
vi. prior to submission of the ES, the HCP shall confirm the content of ES and shall be able to edit wherever necessary, except for the demography information;
vii. the ES shall be completed on the same working day; and
viii. in the event the ES is prepared by a house officer (HO), the medical officer shall then verify the ES. (*Borang* PER/ES/2015).

Discharge Summary (DS)

i. the DS is a summary of the patient's illness and management during the episode of stay in the hospital or institution;
ii. the DS shall be prepared by any medical practitioner once the patient is discharged from the ward regardless of discharge type;
iii. the medical practitioner who is a medical officer shall verify the DS if it is prepared by a HO and the format shall be in accordance with Borang PER/DS/2015 or PER PD 302;
iv. in multidisciplinary care, the DS shall be prepared by each discipline once the patient is discharged from that discipline;
v. all discharge summaries from each discipline shall be auto-populated in the final DS;
vi. the medical practitioner from the discharging discipline shall prepare the final DS;
vii. the medical practitioner shall ensure the completeness of the DS by entering the Principal Diagnosis, Secondary Diagnosis, Co-morbidities, Complications and etc. in view of the MyCMX Casemix and costings;
viii. the DS of a deceased patient shall be prepared using the similar format of DS and shall make available information regarding patient's death;
ix. discharge note shall be filled and handed over to the patient or next of kin during the discharge process.
x. the DS in the EMR shall be accessible in accordance with the UACP and shall purely for the purpose of read-only; and
xi. a discharge note shall be filled and handed over to the patient or next of kin during the discharge process.

5.8.4 Access and Data Sharing

a

Principle to sharing of data;[50]
i. confidentiality of patient data is utmost important;
ii. weigh the benefits and risks of sharing data pertaining to the patient as an individual, to the HCP and the organisation (stakeholder/institution/hospital); and
iii. responsibility of the HCP for data to be shared.

b

In general, the EMR may only be accessed in the following condition;
i. when the patient is enrolled in a healthcare facility;
ii. when the patient is referred to a healthcare facility;
iii. in certain cases, under the jurisdiction of the director of a healthcare facility, which may include for updating national registry, quality initiative activities and etc.;

iv. for coding by the Medical Record Officer (MRO), HCP or other authorised personnel;
v. on case to case basis, upon need-to-know for clinical purposes, only for registered medical personnel and the access may audited, trailed and monitored by MRO and appointed personnel; and
vi. the Hospital or Institution Director shall be responsible to determine clearly the access pertaining to high profile or medicolegal cases.

c

Printing or copy of EMR;
i. the printing of any part of the EMR is not allowable, except for;
   - referral purposes; or
   - consent forms to be signed manually;
ii. the printing of any part of the EMR shall be with the permission of the Hospital or Institution Director or under a court order; and
iii. the printing shall be done in the Medical Record Department or Unit but the referral letters or consent forms or specified identified documents may be printed in the ward or clinic.

d

Purpose of EMR access;
i. access for the continuity of patient care;
   - may be accessed by end users based on UACP;
   - the clinical support service officers may access demographic and clinical data of patients who received consultation in their disciplines;
   - supporting staff shall access only in their duty place;
   - access shall be deactivated after 72 hours (working day) for in-patient service and after 24 hours (working day) for out-patient services upon patient discharge; and
   - sharing of discharge summary between the MOH's facilities as well as with the private healthcare facilities may be allowed with patient consent.
ii. access to data within government facilities shall be subject to written approval by the Hospital or Institution Director and compliance with current act of relevant agencies, and may be granted to both internal and external customers under the following conditions:

1. **For internal customer;**
   - all applications shall be made through the system via Medical Record Module;
   - the EMR access shall be made under the name of the applicant with the approval of the Hospital or Institution Director or any authorised personnel;
   - only specifically approved EMR may be accessed by the requestor; and
   - the validity of access right is only up to two (2) weeks.
2. **For external customers;**
   - external customers are defined as any person who are not working at the healthcare facility;
   - a written approval from the Hospital or Institution Director or authorised personnel shall be obtained before access is given;
   - upon approval, a temporary access shall be given to the requestor by the system administrator;
   - the external customers shall comply with the research guidelines endorsed by the National Medical Research Registry (NMRR) and Medical Research and Ethic Committee (MREC)
   - information sharing between MOH and the other governmental agencies is allowable subject to the mutual agreement between the ministries; and
   - MOH and the respective governmental agency shall have an MOU prior to data sharing.

5.8.5 Amendment and Addendum

a

Amendment;

i. amendment is any change made to the original record such as addition, deletion and substitution;
ii. there shall be no amendment allowed for encounter summary or discharge summary;
iii. in the EMR, all amendments shall be made using soft delete (strikethrough), and a new entry shall be added in italics next to the deleted entry;
iv. the EMR system shall be able to show the date and time of changes made;
v. the EMR system shall not allow "cut and paste" functions for amendment purposes;
vi. any amendment may only be performed in the presence of the client or patient and within 72 hours of discharge; and
vii. any amendment deemed necessary after 72 hours of discharge shall;
   - require an approval from the MRO with permission by the HOD; and
   - be permitted a grace period of 14 days for the amendment to be made.

b

Addendum;

i. addendum is an edition to the EMR in any form of data and images;
ii. reasons of addendum shall include but not limited to update of investigation results, addition of Medical Certificate and referral letter;
iii. addendum shall be allowed to the encounter summary or discharge summary provided data to be added to the primary document prior to the encounter summary or discharge summary;
iv. there shall be no time limit for addendum to be done;
v. after 72 hours of patient discharge, any request for addendum shall;
   - require an approval from the MRO with permission by the HOD; and
   - be permitted a grace period of 14 days for the addendum to be made;
vi. there is no limit in terms of the quantity of addendum to be made;
vii. the types of documents for the purposes of addendum shall be decided by the healthcare facility;
viii. the EMR system shall be able to capture and display;
   - the identity of the person who made the addendum, date and time performed; and
   - the reason for the addendum.

5.8.6 Contingency Plan During System Downtime

a

As part of the Business Continuity Management System (BCMS) objectives, the hospital or institution shall be committed to establishing effective business continuity management plans to protect its key business activities;

b

The ITD shall establish the BCP for ICT as part of its contingency plan in the event of ICT systems disruption;

c

The BCP shall provide a comprehensive understanding of the total effort required to continue a patient's treatment during system downtime whenever a planned or unplanned downtime of the HIS system occurs;

d

The patient information and manual forms shall be made available and shall be stored at the BCP Contingency PC for the department or unit's users to use for the continuity of services in the event of HIS system disruption; and

e

The BCP shall be tested at regular intervals through walkthroughs or simulation exercises to improve user readiness and ensure the plan remains relevant.

5.9 QUALITY MANAGEMENT

5.9.1 Standards and Indicators

a The National Indicators, Key Performance Indicators (KPI), National Key Result Areas shall be used to monitor the hospital or institution performance in quality care.

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

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

5.9.2 Quality Improvement Activities

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

b The following quality activities shall be implemented:

i. Credentialing and Privileging;
ii. NIA/KPI/HPIA;
iii. Quality assurance studies;
iv. Quality Control Circle (KIK);
v. Malaysian Patient Safety Goals;
vi. Patient Satisfaction Questionnaire (PSQ-18);
vii. Incident reporting/Root Cause Analysis (RCA);
viii. Clients Charter;
ix. ISO 9000 certification;
x. Hospital Accreditation Certification (MSQH);
xi. Clinical Audit;
xii. *Ekosistem Kondusif Sektor Awam* (EKSA);
xiii. Morbidity and Mortality Reviews (suspicious death, perioperative and postoperative death, maternal mortality, perinatal and neonatal mortality, specific communicable diseases death such as dengue, tuberculosis, leptospirosis and others in accordance with Notifiable Disease Act);
xiv. Pain Free Hospital;
xv. Baby Friendly Hospital; and
xvi. patient and family rights.[55-64]

c All activities on quality improvement shall adhere to existing MOH guidelines and procedures.

d All departments and units in the hospital or institution shall;

i. be responsible for the provision of quality and safe service; and
ii. establish their own standards and indicators for monitoring quality.

5.9.3 Business Continuity Management System

a The hospital or institution, as much possible, shall establish:
i. *Jawatankuasa Pemandu* (Steering Committee) Business Continuity Management System (BCMS) to oversee and to ensure the continuity of critical services in the face of any disruptive event; and
ii. *Jawatankuasa Pelaksana* (Task Force) to coordinate all activities before, during and after disruption based on Quality Management concept Plan, Do, Check and Act (PDCA).

b The BCMS Steering Committee shall monitor strategy and plan based on Recovery Time Objective, Maximum Tolerable Period Down Time (MTPD) and Workaround Strategy of the service according to the outlined strategies.

c The departments or units in the hospital or institution shall;
i. be responsible for the provision of BCMS implementation for continuity of the services; and
ii. establish the BCMS documents according to ISO 22301:2019 requirements and meet Business Continuity Management (BCM) objectives.

d The departments or units shall also comply with the following BCM objectives;
i. to establish leadership commitment in BCMS;
ii. to establish holistic risk management strategy;
iii. to protect against disruptive event which shall include the service, human resource, information and assets;
iv. to maintain formal documented process;
v. to ensure availability of resources;
vi. to contain and minimise impact of disruption;
vii. to identify and establish communication needs;
viii. to embed BCM culture and promote BCM awareness; and
ix. to establish methods to monitor and evaluate BCMS implementation.

1 *Surat Edaran Ketua Pengarah Kesihatan – Laluan Khas kepada Banduan Semasa Menerima Rawatan Luar dan Pengambilan Ubat di Hospital atau Klinik Kerajaan, bertarikh 22 Disember 2016.*

2 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 1, Tahun 2005 – Garis Panduan Pengurusan Masa Menunggu di Klinik-klinik Pakar dan di Jabatan Kecemasan di Hospital-hospital KKM, bertarikh 1 Jun 2005.*

3 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 6, Tahun 2004 – Langkah-langkah untuk Mengurangkan Masa Menunggu di Kemudahan-kemudahan Kesihatan, bertarikh 20 Julai 2004.*

4 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 3, Tahun 1985 – Lawatan Pegawai-pegawai Pakar ke Hospital-hospital Daerah, bertarikh 28 Jun 1985.*

5 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 5, Tahun 1988 – Perkhidmatan Kemalangan dan Kecemasan di Hospital-hospital, bertarikh 20 Januari 1988.*

6 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 3, Tahun 1989 – Maklumat Untuk Orang Ramai Mengenai Penggunaan Perkhidmatan Kecemasan di Hospital-hospital Kerajaan, bertarikh 14 Oktober 1989.*

7 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 10, Tahun 2013 – Garis Panduan Penubuhan Unit Perkhidmatan Pra Hospital di Jabatan Kecemasan dan Trauma Hospital-hospital KKM, bertarikh 11 November 2013.*

8 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 17, Tahun 2012 – Penambahbaikan Garis Panduan Latihan Pemanduan Ambulan KKM, bertarikh 15 Mei 2012.*

9 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 2, Tahun 2012 – Garis Panduan Penambahbaikan Perkhidmatan Ambulan KKM, bertarikh 10 Januari 2012.*

10 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 7, Tahun 2019 – Pelaksanaan Policy on Safety of Land Ambulances, bertarikh 31 Disember 2019.*

11 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 2, Tahun 2009 – Garis Panduan Rujukan dan Perpindahan Pesakit di antara Hospital-hospital Kementerian Kesihatan, Mei 2009.*

12 *Surat Edaran Timbalan Pengarah Kesihatan (Perubatan) – Penggunaan Protokol Malaysian Triage Scale 2022, Ke Arah Penyeragaman Kaedah Saringan Pesakit di Kaunter Triage Jabatan Kecemasan dan Trauma, Hospital-hospital KKM, bertarikh 17 April 2023.*

13 *Emergency Medicine and Trauma Services Policy, 2012.*

14 *CPG on Early Management of Head Injury in Adults, 2015.*

15 *One Stop Crisis Center (OSCC): Policy and Guidelines for Hospitals, MOH, 2015.*

16 *Panduan Pelan Tindakan Insiden Kecemasan dan Bencana Dalaman bagi Hospital-hospital Kementerian Kesihatan Malaysia, Edisi Pertama, 2019.*

17 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 7, Tahun 2007 – Pelaksanaan Perkhidmatan Klinik Rawatan Pesakit Selepas Waktu Pejabat (KRPSWP) di Jabatan Kecemasan, bertarikh 16 Ogos 2007.*

18 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 2, Tahun 2007 – Liputan Pasukan Perlindungan Perubatan dan Kesihatan KKM, bertarikh 15 Jun 2007.*

19 *Polisi Perkhidmatan Rawatan Harian di Hospital-hospital Kementerian Kesihatan Malaysia, 2016.*

20 *Daycare Surgery Standard Operating Procedure, 2016.*

21 *Protocols for Day Care Anaesthesia, 2017.*

22 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 4, Tahun 2018 – Penambahbaikan Pelaksanaan Safe Surgery Saves Lives Programme di Hospital dan Institusi Perubatan Kementerian Kesihatan Malaysia, bertarikh 20 September 2018.*

23 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 7, Tahun 2008 – Pelaksanaan Pembedahan Elektif pada Hari Sabtu di Hospital-hospital Kerajaan yang dikenal pasti, bertarikh 7 Julai 2008.*

24 *Anaesthesiology & Intensive Care Services Policy, Second Edition, 2013.*

25 *The ICU Networking Services Guidelines, 2008.*
26 *Disinfection Guidelines, 2nd Edition, 2019.*
27 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 10, Tahun 2012 – Standard Operating Procedures of Forensic Medicine Services, bertarikh 22 Februari 2012.*
28 *Operational Policy in Pathology Services (2nd Edition), (October 2021).*
29 *National Radiology Services Operational Policy, First Edition, 2019.*
30 *Polisi Operasi Farmasi Ambulatori 2022 (Edisi Kedua), Januari 2022.*
31 *Surat Pekeliling Ketua Setiausaha KKM, Bilangan 1, Tahun 2025 – Penambahbaikan Pelantikan dan Peranan Ahli Lembaga Pelawat Hospital Kementerian Kesihatan Malaysia, bertarikh 10 Mac 2025.*
32 *Garis Panduan Pembukaan Akaun Bank Ahli Lembaga Pelawat Hospital (ALPH) dan Perbelanjaan Secara Berhemah bagi Peruntukan Kewangan yang disalurkan, bertarikh Mac 2025 (Bahagian Kewangan KKM).*
33 *Surat Pekeliling Ketua Setiausaha KKM, Bilangan 3, Tahun 2011 – Urusan Perlantikan dan Peranan Ahli Lembaga Pelawat Hospital Psikiatri, Kementerian Kesihatan Malaysia, bertarikh 23 Mac 2011.*
34 *Surat Edaran Bahagian Khidmat Pengurusan KKM – Bayaran Elaun Mesyuarat bagi Ahli Lembaga Pelawat Hospital dan Ahli Lembaga Pelawat Hospital Psikiatri KKM, bertarikh 4 November 2009.*
35 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 13, Tahun 2017 – Garis Panduan Penubuhan Lembaga Perubatan di Fasiliti KKM, bertarikh 29 Disember 2017.*
36 *Surat Pekeliling Ketua Setiausaha KKM, Bilangan 5, Tahun 2018 – Garis Panduan Pengurusan Hospital Kluster dan Hospital Cluster Policy Framework, bertarikh 20 Disember 2018.*
37 *Surat Edaran Timbalan Ketua Pengarah Kesihatan (Perubatan) – Makluman Senarai Terkini 40 Hospital Kluster Kementerian Kesihatan Malaysia bertarikh, 24 Oktober 2023.*
38 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 2, Tahun 2015 – Garis Panduan Pelaksanaan Perintah Fi (Perubatan) (Pesakit Bayar Penuh) 2007 (Semakan 2015), bertarikh 19 Mac 2015.*
39 *Surat Edaran Bahagian Perkembangan Perubatan – Edaran Dokumen-dokumen Program Hospital Mesra Ibadah: Polisi dan Garis Panduan Pelaksanaan Program Hospital Mesra Ibadah (Perspektif Islam), bertarikh 09 November 2017.*
40 *Surat Pekeliling Ketua Setiausaha KKM, Bilangan 5, Tahun 2006 – Tatacara Pelaksanaan Pegawai Perubatan dan Pergigian Berdaftar Melakukan Pekerjaan Luar (Lokum), bertarikh 1 Disember 2006.*
41 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 2, Tahun 2010 – Garis Panduan Pelaksanaan Melakukan Pekerjaan Luar (Lokum) di Sektor Swasta oleh Pegawai Perubatan KKM, bertarikh 12 Mac 2010.*
42 *Surat Pekeliling Ketua Setiausaha KKM, Bilangan 9, Tahun 2015 – Garis Panduan Permohonan Kelulusan Melakukan Pekerjaan Luar/Kerja Sambilan bagi Penjawat Awam di KKM, berkuatkuasa 12 November 2015.*
43 *Surat Pekeliling Ketua Pengarah Kesihatan, Bil. 10, Tahun 2017 – Garis Panduan Waktu Kerja Fleksi bagi Pakar Perubatan Gred UD54 dan Ke Atas di KKM, bertarikh 6 Disember 2017.*
44 *Pekeliling Perkhidmatan, Bilangan 11, Tahun 2017 – Pelaksanaan Kebenaran Pulang Awal Satu Jam Kepada Pegawai Wanita Mengandung, berkuatkuasa 1 Januari 2018.*
45 *Lean Healthcare Operational & Sustainability Guideline, Second Edition, August 2023.*
46 *Garis Panduan Aliran Pengurusan Pesakit di Hospital Kementerian Kesihatan Malaysia 2022 (Bahagian Kejururawatan).*
47 *Garis Panduan Penubuhan Unit Perubatan Tradisional dan Komplementari, Edisi Pertama, 2015.*
48 *Standard Operating Procedures for the Traditional and Complementary Medicine Unit in the Ministry of Health Hospitals, Third Edition, 2023.*
49 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 5, Tahun 2023 – Garis Panduan Pengendalian dan Pengurusan Rekod Perubatan Pesakit di Fasiliti Kementerian Kesihatan Malaysia, bertarikh 14 Februari 2023.*
50 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 13, Tahun 2011 – Dasar dan Garis Panduan 'User Access Control Policy' (UACP) bagi Sistem Maklumat Hospital dan Klinik (HIS/CIS) Kementerian Kesihatan Malaysia, bertarikh 13 Disember 2011.*

51 *Jadual Pelupusan Rekod Perubatan 2016 di Fasiliti Kementerian Kesihatan Malaysia.*

52 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 16, Tahun 2010 – Garis Panduan Penyediaan Laporan Perubatan di Hospital-hospital dan Institusi Perubatan, bertarikh 4 Jun 2010.*

53 *Surat Edaran Bahagian Perkembangan Perubatan – Pemberian "Discharge Note" Menggantikan "Discharge Summary" Kepada Pesakit, Rujukan KKM 87/P1/11/1(29) Jld.7, bertarikh 12 November 2010 and Letter Bil KKM.600-1/4/20 JLD 3 (24), bertarikh 4 November 2019.*

54 *Laporan Tahunan Rawatan Perubatan, Tahun 2023.*

55 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 4, Tahun 2023 – Polisi Mengenai Akreditasi di Fasiliti dan Perkhidmatan Penjagaan Kesihatan, bertarikh 14 Februari 2023.*

56 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 1, Tahun 2020 - Keselamatan Pesakit Agenda Utama Perkhidmatan Kesihatan, bertarikh 17 Januari 2020.*

57 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 22, Tahun 2021 – Pelaksanaan Inisiatif Malaysian Patient Safety Goals 2.0 di Fasiliti Kesihatan dan Institusi Perubatan, bertarikh 7 Disember 2021.*

58 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 23, Tahun 2021 – Pelaksanaan Arahan Berkaitan Pengurusan "Unintended Retained Surgical Item", bertarikh 7 Disember 2021.*

59 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 9, Tahun 2017 – Pelaporan Insiden di Hospital dan Institusi Perubatan Kementerian Kesihatan Malaysia Menggunakan Sistem Incident Reporting and Learning System 2.0., bertarikh 5 Disember 2017.*

60 *Guidelines on Implementation of Incident Reporting & Learning System for Ministry of Health Hospitals, 2017.*

61 *Pekeliling Transformasi Pentadbiran Awam, Bilangan 1, Tahun 2018 – Panduan Pelaksanaan Sistem Pengurusan Kualiti Berasaskan MS 9001:2015 bagi Sektor Agensi Sektor Awam.*

62 *MSQH 6th Edition Standards.*

63 *Pain Free Manual, 3rd Edition, 2023.*

64 *Pain as The 5th Vital Sign Guideline, 3rd Edition, 2018.*

65 *Garis Panduan Pengurusan Program Sekolah Dalam Hospital, Kementerian Pendidikan Malaysia, Edisi 2024.*

66 *ICU Management Protocols, 2019.*

67 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 11, Tahun 2025 – Garis Panduan Ahli Lembaga Pelawat Hospital Kementerian Kesihatan Malaysia, bertarikh 21 April 2025.*

CHAPTER

06 HUMAN RESOURCE GOVERNANCE


HOSPITAL
CYBERJAYA

06 Human Resource Governance

6.1 HUMAN RESOURCE

6.1.1 Staffing Strategy

Human resource training shall be conducted in alignment with service requirements and expansion plans.

6.1.2 Orientation

6.1.3 Placement

a. Staff placement in departments or units shall be based on qualifications, specialised training and service needs.

b. All head of department or unit shall be responsible for staff placement and job descriptions within their respective departments or units.

c. Deployment and rotation of staff to other departments or units may be conducted as and when necessary.

d. Staff placement between clusters, as much as possible, shall require permission from the head of the cluster and CMC, along with the relevant justification.

6.1.4 Work Attendance and Leave

a. All staff shall record their daily attendance and movements during working hours using the designated personnel attendance system.

b. All specialists or MOs visiting the non-lead cluster hospitals or institutions shall report their presence or duty to the non-lead Hospital or Institution Director.

c. All HOD shall monitor the daily attendance or movements of their staff.

d. Leave applications shall be submitted in advance and approved before leave is taken and the utilisation of HRMIS for leave applications is required.[1]

e. All staff shall inform their HOD if they are unwell and shall provide a valid Sick Certificate.

f. Any staff participating in any approved Medical and Humanitarian Aid Missions, shall be granted non-recorded leave, including travel days, weekends and public holidays, for a maximum of 21 days as per guidelines.[2]

g. Any staff travelling abroad shall obtain approval through the designated form or HRMIS and shall have adequate insurance coverage for international travel.[3,4]

6.2 PROFESSIONAL DEVELOPMENT AND COMPETENCY

6.2.1 CPD Programme

a. The hospital or institution management shall facilitate the Continuing Medical Education (CME) and Continuing Professional Development (CPD) activities.

b. All staff shall be responsible for their own professional development to improve work performance.

c. The head of department or unit shall suggest appropriate training for the individual staff to develop their knowledge and skill.

d. All staff shall be required to attend the CME or CPD or Training programme sessions every year and where applicable, log books or online CPD shall be updated regularly.[5]

6.2.2 Performance Evaluation

a. Each staff member shall have their own Job Description (JD) in MyPortfolio which shall contains the job description, responsibilities and related work guidelines and procedures.

b. All staff, in consultation with the respective heads of departments or units shall prepare the Main Work Targets namely the MyPerformance - Sasaran Kerja Utama (SKU) and indicators (e.g. KPI) for measuring achievement at the beginning of the year.

c. All departments or units shall have its own system to monitor and evaluate staff technical competencies.

d. The performance evaluation shall be carried out six (6) monthly and annually and at appropriate intervals using the standard format in a just and fair manner.

e. Any specialists who have served for more than 10 years from the gazette date may apply to be evaluated or recognised as Consultant Specialists through the appointing committee (MAC or MDAC).[6]

6.2.3 Credentialing and Privileging

a. Each hospital or institution shall establish a structural organisation and mechanism for purposes of credentialing or privileging or both, of clinical staff relevant to the type of services being offered.

b. For certain work processes in HIS hospital or institution, the Head of Departments or Units shall identify any officer to be credentialed and support their applications and they shall then approve the application.

c. All non-government medical practitioners practicing in a government facility as university lecturers, locum, training attachments or on sessional basis shall be required to obtain a written approval to practice in a government facility, in accordance with Section 34C of the Medical Act 1971 and they shall be credentialed accordingly.[21-23]

6.3 ETHICS AND DISCIPLINE

6.3.1 Dress Code and Work Behaviour

a. The values of MOH Corporate Culture including caring, teamwork and professionalism shall be internalised and upheld by all staff while performing their duties.[7,8,9]

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

c. All staff shall wear their respective uniforms or proper working attire.[8,10]

d. Batik attire shall be compulsory every Thursday and encouraged on other working days.

e. Staff who are provided with uniforms shall be exempt from wearing batik attire, including those who wear lab coats.[11]

f. Name tags and hospital or institution identification cards shall be worn at all times as part of the uniform or working attire.[7]

g. Scrub uniforms or clinical attire shall be allowed to be worn in clinical areas only as stipulated in the relevant guideline.[20]

6.3.2 Disciplinary Action

a. Monitoring of staff performance shall be continuous.[5]

b. Staff with disciplinary issues shall receive counselling before being referred for disciplinary action.[12,13]

6.4 STAFF WELLBEING, SAFETY AND SECURITY

a. The hospital or institution shall establish clubs or associations such as Sports and Welfare Club or *Puspanita* to provide opportunities for staff to gather, participate in sports or recreational activities, and promote staff welfare.

b. The Ex-Gratia Work Disaster Scheme shall provide compensation to the hospital or institution staff affected by disasters while carrying out work that results in permanent disability or death, including those victimised due to actions taken in the course of official duties.[14]

c. A Work Disaster refers to a disaster suffered by an officer caused by an accident while performing official duties or an occupational disease.

d. Any hospital or institution staff shall be covered during the following periods;
   i. while commuting between home and the workplace;
   ii. while commuting between the workplace and residence during approved meal times; and
   iii. at all times while on official duty.

e. A hospital or institution or their beneficiaries shall complete Part A of the BTX Form, available through the Treasury website.

f. Completed forms shall be submitted to the Head of Department, who shall investigate and prepare a report on the disaster, completing Part B of the form before submission to the State Health Department and MOH along with the required documents.

6.5 TRAINING

6.5.1 Professional Development

a. Each hospital or institution shall establish a structural organisation to provide the direction and governance for the CPD programme.[5]

b. To maintain staff competency, which shall include technical, soft skill and communication skill, each staff (both administrative and clinical), as much as possible, shall be given the opportunity to attend training programmes in areas relevant to their functions and not less than five (5) days.

c. Each hospital or institution shall be encouraged to establish formal and informal linkages and collaborations with local and international health-related organisations to facilitate training activities.

d. Databases of in-house and external training programmes organised and/or attended by each staff shall be maintained and updated.

e. As different hospital or institution staff shall require different CPD points, the hospital or institution shall alert and update their staff regarding the latest CPD grading system for each staff.

f. All practicing hospital or institution staff shall be required to renew their APC every year.

6.5.2 Assessment

a. Any hospital or institution that has been designated as a training centre for undergraduates/ House Officers and/or other post-basic/graduate programmes shall be required to establish a formalised training and assessment structure relevant to the type of training being provided.[15]

b. The undergraduate activities shall be coordinated and monitored under the Joint Management Committee at the state level.

c. At the hospital or institution level, the Hospital or Institution Director shall ensure that the postgraduate activities are well coordinated and monitored.

6.6 GIFT AND DONATION

Any hospital or institution staff shall not receive or donate gifts related to their duties unless with the permission as stated in the relevant guideline.[16]

6.7 RESEARCH

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

b. Hospital or institution with an established Clinical Research Centre (CRC) under the network CRCs in the MOH shall have a structural organisation and facilities to provide governance, guidance and support for research activities.[17-19]

c. All research undertaken by the MOH staff or conducted in MOH facilities or funded by MOH research grant shall require the following;
   i. prior registration with the National Medical Research Register of the MOH; and
   ii. prior approval by the MOH.

d. All publications, whether in the form of research reports, journal articles or conference proceedings, arising of research undertaken by MOH staff or conducted in MOH facilities or funded by MOH research grants, shall require prior review by the NIH and subsequent approval by the Director General of Health.

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

f. The hospital or institution shall tag and maintain medical records of patients involved in clinical trials including all relevant research documents.

g. Proper management of records after expiry dates e.g., disposal and archiving shall be carried out in collaboration between the Medical Records Unit and Hospital or Institution CRC.

1 *Surat Edaran Timbalan Ketua Pengarah Perkhidmatan Awam (Pembangunan) – Peraturan Mengenai Kebenaran untuk Meninggalkan Pejabat Dalam Waktu Bekerja di Bawah Perintah Am 5 Bab G – Mematuhi Waktu Bekerja, bertarikh 9 Disember 2009.*

2 *Surat Edaran Ketua Setiausaha KKM – Garis Panduan Permohonan ke Luar Negara bagi Pegawai KKM yang Akan Menyertai Misi Bantuan Kemanusiaan, bertarikh 19 Jun 2017.*

3 *Surat Edaran Ketua Pengarah Perkhidmatan Awam – Kemudahan Perlindungan Insurans Kesihatan Kepada Pegawai Perkhidmatan Awam yang Berada di Luar Negara atas Urusan Persendirian, bertarikh 16 Januari 2019.*

4 *Surat Pekeliling Am, Bilangan 3, Tahun 2012 – Peraturan Perjalanan Pegawai Awam ke Luar Negara Atas Urusan Persendirian, bertarikh 1 Oktober 2012.*

5 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 4, Tahun 2007 – Pelaksanaan Pembelajaran Profesional Berterusan (Continuing Professional Development (CPD), bertarikh 11 Julai 2007.*

6 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 24, Tahun 2022 – Garis Panduan Penggunaan Gelaran Pakar Perubatan Perunding, bertarikh 22 November 2022.*

7 *Surat Pekeliling Am, Bilangan 8, Tahun 1983 – Pemakaian Tanda Nama, bertarikh 14 Oktober 1983.*

8 *Laman sesawang MyPPSM Jabatan Perkhidmatan Awam – Ceraian UP.7.2.3: Etiket Pakaian dan Penampilan Pegawai Awam.*

9 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 1, Tahun 2000 – Amalan Etika Profesion Perubatan yang Baik, bertarikh 26 Mei 2000.*

10 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 4, Tahun 1989 – Kod Pakaian untuk Doktor, bertarikh 26 Oktober 1989.*

11 *Surat Edaran Ketua Pengarah Perkhidmatan Awam – Pemakaian Pakaian Batik Malaysia Semasa Waktu Bekerja bagi Pegawai Perkhidmatan Awam Persekutuan, bertarikh 21 Ogos 2023.*

12 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 3, Tahun 1987 – Penyeliaan Doktor-doktor di Jabatan Klinikal, bertarikh 6 April 1987.*

13 *Laman sesawang MyPPSM Jabatan Perkhidmatan Awam – Urusan Perkhidmatan UP.7: Tatakelakuan dan Pengurusan Tatatertib.*

14 *Pekeliling Perbendaharaan, Bilangan 7, Tahun 2001 – Pindaan Bayaran di bawah Skim Ex-Gratia Bencana Kerja Bagi Anggota Perkhidmatan Awam.*

15 *Buku Panduan Program Pegawai Perubatan Siswazah, Edisi 2012.*

16 *Laman sesawang MyPPSM Jabatan Perkhidmatan Awam – Urusan Perkhidmatan UP.7.2.5: Pengurusan Penerimaan atau Pemberian Hadiah, Keraian dan Tajaan Dalam Perkhidmatan Awam.*

17 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 10, Tahun 2015 – Garis Panduan Institut Kesihatan Negara Mengenai Penyelidikan di Institusi dan Fasiliti Kementerian Kesihatan Malaysia (Pindaan 01/2015), bertarikh 21 Oktober 2015.*

18 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 3, Tahun 2017 – Garis Panduan Institut Kesihatan Negara (National Institutes of Health–NIH) Mengenai Permohonan Geran Penyelidikan Kementerian Kesihatan Malaysia, bertarikh 5 Mei 2017.*

19 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 2, Tahun 2024 – Penyelidikan Klinikal, Institut Penyelidikan Klinikal (ICR) serta Rangkaian Pusat Penyelidikan Klinikal (CRC) di Hospital dan Penubuhan Jawatankuasa Penyelidikan di Peringkat Hospital dan Negeri, bertarikh 26 Februari 2024.*

20 *Surat Edaran Bahagian Perkembangan Perubatan – Pemakaian Personal Scrub Suit Semasa Bertugas di Hospital KKM, bertarikh 7 November 2024.*

21 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 11, Tahun 2008 – Panduan Bagi Penggunaan Khidmat Doktor Swasta untuk Perkhidmatan Kesihatan di Klinik Kementerian Kesihatan Malaysia (Hospital dan Klinik Kesihatan) Dengan Kadar Baru RM80 Sejam, bertarikh 24 Ogos 2008.*

22 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 4, Tahun 2001 – Garis Panduan Pengambilan Pakar Swasta Untuk Berkhidmat di Hospital-hospital Kerajaan, bertarikh 22 Februari 2001.*

23 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 1, Tahun 2001 – Garis Panduan Prosedur-prosedur Dalam Sistem Credentialing dan Privileging di Kementerian Kesihatan Malaysia.*

CHAPTER

07 PATIENT GOVERNANCE


HOSPITAL
KUALA LIPIS
AMBULANS
AMBULANS

07 Patient Governance

7.1 PATIENTS' RIGHT

Patient governance refers to the systems and processes in place to ensure that patients receive good-quality, safe, and fair healthcare.

a. Patients have certain rights when they receive medical care and a statement shall be outlined on their rights.

b. The statement shall include giving them information, treating them fairly, and letting them make their own decisions about their health

c. The hospital or institution shall uphold the rights of patients, respecting their cultural, spiritual, and religious beliefs, as well as those of their families.[1]

d. No patient shall face discrimination based on race, gender, sex, religious beliefs, social or economic status or any other factors.

e. The hospital or institution shall bear the responsibility for ensuring the safety of patients during their stay.[2]

f. Patient confidentiality, including personal data and medical information, shall be maintained by the hospital or institution.

g. Treatment shall be tailored to each patient's clinical condition, providing individualised care that is safe and of high quality.

h. The hospital or institution shall be obliged to communicate with patients and their families regarding the patient's condition and available treatment options, involving them in decision-making processes.[3]

i. Patient and family decisions shall be respected. Vice versa patient and family shall provide accurate information regarding their illness, medical history, previous admission history and other related matters.

j. In HIS hospitals or institution, discharge summaries shall be shared through Health Information Exchange (HIE) initiatives.

k. By default, patient discharge summaries shall be sent to the HIE repository, although patients have the right to opt out after receiving proper counselling.

l. Patients shall have the right to access information about payments and may request detailed bills from the Revenue Unit.

7.2 CONSENT

a. Every patient shall have a choice whether or not to undergo a proposed procedure, surgery, treatment or examination.

b. Informed consent usually refers to the idea that a person shall be fully informed and understand of the potential benefits and risks of their choice of treatment.

c. An uninformed person shall usually be at risk of mistakenly making a choice not reflective of his or her values or wishes.

d. Obtaining a patient's consent shall be a specific legal requirement and shall be part of good medical practice.

e. Consent shall be obtained from the patient or next of kin prior to carrying out any clinical procedures.

f. Consent shall be obtained from the patient if he or she is 18 years old or more and mentally competent.

g. In a life-saving situation where all efforts to trace the next of kin and family have failed, two clinical specialists, one of whom shall be from the related discipline, may give consent for the procedure to be carried out.

h. The consent and efforts made to trace the next of kin or family shall be documented in the case notes.

i. All consent or refusal shall be taken by a medical officer or specialist performing the procedure using the appropriate consent or refusal forms or methods.

j. The communication shall include but not restricted to:
   i. patient's condition;
   ii. proposed treatment or procedure;
   iii. potential benefits and risks;
   iv. likelihood of success or failure;
   v. possible alternatives;
   vi. possible problems related to recovery; and
   vii. possible results of non-treatment.

k. For patients below the age of 18 or mentally incompetent patient, consent shall be obtained from the legal guardian.

l. Consent shall also be obtained from the patient or next of kin when body parts or organs are taken for academic or research use.

m. For a mentally disordered patient who is required to undergo surgery, electroconvulsive therapy or clinical trials, consent for any of them may be given by:
   i. the patient himself, if he is capable of giving consent as assessed by a psychiatrist;
   ii. his guardian in the case of a minor or a relative in the case of an adult, if the patient is incapable of giving consent; and
   iii. two (2) psychiatrists, one (1) of whom shall be the attending psychiatrist, if there is no guardian or relative of the patient or traceable and the patient himself is incapable of giving consent.[4]

n For a patient below the age of 18 who requires treatment, consent shall be obtained as the following;
   i. if, in the opinion of a registered medical practitioner, the patient requires treatment due to serious illness, injury or condition, the consent shall be given by the parents or legal guardian of the child; and
   ii. if, the registered medical practitioner has certified in writing that there is an immediate risk to the health of a child and medical or surgical or psychiatry treatment is necessary, two (2) medical practitioners or a *Protector may authorise without having to obtain the consent from the parents or legal guardian of the child, but only under any of the following circumstances;
      - unreasonably refuse to give, or abstained from giving consent to such treatment;
      - not available or cannot be found within a reasonable time; and
      - the Protector believes on reasonable grounds that the parents or legal guardian or the authorised person has ill-treated, neglected, abandoned or exposed, or sexually abused the child.

Note: *According to Child Act (Amendment) 2016, Protector is defined as the Director General, the Deputy Director General, a Divisional Director of Social Welfare, Department or Social Welfare, the State Director of Social Welfare of each of the State or any Social Welfare officer appointed.[5]

o In HIS hospitals or institutions;
   i. the consent forms shall be generated from the system and printed out for signature of the relevant parties (medical practitioner, patient or legal guardian, witness);
   ii. all signed consent forms shall be filed and stored by the Medical Records Department;
   iii. in the era of advanced technology, digital signature shall be adopted when such a facility is made available; and
   iv. the function of scanning and uploading of the signed document shall be made available in the system.

7.3 CONSULTATION

a The hospital or institution shall ensure the safety, confidentiality and privacy of the patients throughout consultation and examination.

b All patients at the Specialist Clinic shall be managed by the medical practitioner relevant to the particular illness or specialty.

c The management of patients shall be documented in the designated clerking forms manually or in CD of HIS.

d All assessments and entries by nurses and other allied health professionals shall be documented in the patient's case notes as integrated case notes.

e Any examination of a female patient by a male doctor shall be done in the presence of a chaperone, who is medical personnel and this shall be strictly observed for gynaecological and intimate examination.

7.4 REFERRAL SYSTEM

7.4.1 General

a Transfer of patients may occur routinely or as part of a regionalised plan to provide optimal care for patients at more appropriate and/or specialised facilities.[6]

b Referral of patients between hospitals or institutions either within or outside clusters may occur from a lower to a higher level of care (step-up care), a higher to a lower level of care (step-down care) or at the same level of care depending on the needs of the patients and/or the providers of care.[7]

c All hospitals or institutions shall develop referral or transfer protocols and criteria for clinical services. Periodic reviews of the referral or transfer pattern with all stakeholders are essential to facilitate efficient flow of continuum of care to the patient.

d The standard treatment guidelines as set out by the Clinical Practice Guideline (CPG) and Care Protocols shall be used as a basis for patient treatment at different levels of care.

e Communications between stakeholders including patients and their families shall be mandatory when referrals are being made.

f Electronic referral system (e-Referral) shall be used when available.

g As for non-IT hospitals or institutions, the use of a standardised referral letter or feedback in two (2) or three (3) copies, to channel clinical information together with relevant or appropriate records (e.g., laboratory results, medication, electrocardiograms, radiographs, and other diagnostic tests) in the referral chain shall be obligatory. The distribution of copies shall be as follows:

i. the first copy shall be sent with the patient;
ii. the second copy shall be given to the pharmacist of the receiving hospital (if necessary); and
iii. the third copy shall be kept in the patient's medical record.

h Teleconsultation (TC) shall be adopted in referral purposes and shall follow the SOP of relevant disciplines.

i Electronic social media consultation or referral shall abide by the MOH Social Media Policy.

j The transport system for both emergency and planned medical transport services shall be well managed to ensure patient and staff safety and quality of transport services and shall also comply with relevant laws and regulations and licensing requirements.

k The mode of transportation (ground, air or water) used for transport shall be determined by the transferring doctor or specialist, after consultation with the receiving doctor or specialist, based on time, weather condition, medical interventions necessary for ongoing life support during transfer, and availability of personnel and resources.

l All medications anticipated during the transport shall be provided by the referring hospital or institution and shall be under the control of the accompanying hospital or institution staff.

m Unless absolutely necessary, the relatives shall not accompany patients during transportation to reduce overloading and avoid impending patient care.

n It shall be the responsibility of the referring hospital or institution to perform a screening examination, determine if referral or transfer to another facility is in the patient's best interest and to initiate appropriate stabilisation measures prior to referral or transfer.

7.4.2 Intra Facility

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

b All patients requiring assisted ventilation from ETD may be admitted directly to the critical care ward after consultation between the specialist and anaesthetist in-charge of the critical care ward.

7.4.3 Inter Facility

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

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

c. The referring individual shall contact the relevant doctor at the receiving hospital or institution to discuss the necessity of transferring the patient and the receiving doctor shall agree to accept the patient prior to the transfer taking place.

d. If the referral is indicated but is not accepted by the receiving medical officer or specialist;
   i. the referring medical officer shall inform their superior (specialist/Hospital or Institution Director);
   ii. the doctor who refuses the referral shall also inform their superior (specialist/Head of Department/Hospital or Institution Director) and shall document their reason and decision; and
   iii. the relevant authorities shall communicate with each other to come to a final decision on the referral or transfer request taking into consideration the patient's interest.

e. The patient's next of kin shall be informed about the process of transfer.

f. In emergency situations when a patient is unable to agree to transfer, and the next of kin is not contactable;
   i. the police shall be informed to help in contacting them;
   ii. the responsibility for transfer rests with the doctor in charge of the patient; and
   iii. the consent of the relatives is not always required.

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

h. The staff accompanying referred cases shall be decided by the medical officer or specialist in charge, after consultation with the receiving hospital or institution.

i. All critical patients shall be accompanied by trained medical staff who are trained in resuscitation.

j. Monitoring of patients shall be done based on the clinical condition of the patient and recorded accordingly.

k. Recording made in the ambulance during the transfer process including observation or treatment performed during the journey, shall be made in duplicates.

l. The duplicate copy shall be kept by the sender and the original document shall be given to the receiving hospital or institution.

m. All documents pertaining to the patient's condition shall be made available to facilitate the transfer and shall include a referral letter with detailed history of the patient and reason for referral, all related radiological images and other investigation results such as blood results.

n. If a patient's clinical condition deteriorates during the transfer and resuscitation is required, the ambulance may enroute to the nearest healthcare facility or be directed immediately to the Emergency Department of the receiving hospital or institution.

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

7.5 ADMISSION

7.5.1 Patient Admission

a. Patient's admission formalities shall be carried out by the Admission Unit.

b. All patients shall be admitted to the respective wards according to their eligibility which shall be as the following;[8]
   i. patients aged 12 years and below shall be admitted to the Paediatric Ward; and
   ii. patients aged 13 to 18 years shall be admitted to the adult ward and shall be accompanied by a parent or guardian.

c. Stable patients from the referring healthcare facility may be admitted directly to the relevant ward after consultation with the ward doctor on call.

d. All referrals for admission shall be in accordance with the existing guidelines.

e. All unstable patients shall be stabilised in the ETD before admission to the ward.

f. All cases seen at ETD shall be classified as new cases.

g. In HIS, the system shall be able to capture re-encounter within 24 hours through alert mechanism for similar or different diagnosis for the purpose of National Indicator Approach (NIA)/KPI of ETD.

h. All maternity-related cases shall be assessed at the point of care. All stable maternity cases (22 weeks and above) shall be sent directly to the Screening Room or Patient Assessment Centre (PAC) and the necessary admission formalities shall be attended to subsequently.

i. Patients shall pay a deposit or produce a guarantee letter on admission in accordance with the following:
   i. Fees (Medical) 1982 (Amendment) Order 2017;
   ii. Fees (Medical) (Cost of Service) Order 2014; and
   iii. Fees (Medical) (Full Paying Patient) Order 2007.

j. Any foreign patient, who are not able to pay a deposit, shall comply with the management of revenue collection as stipulated in the relevant guideline.[9]

k. Where necessary, all poorly ambulating patients shall be transported on mobile beds, transport trolleys (incubator or cot bed or bassinet) or wheelchairs and shall be accompanied by a medical staff.

l. In cases where the patient is not accompanied and never arrives at the ward within four (4) hours of inpatient registration (no show to ward);
   i. the admission shall be considered to have taken place;
   ii. no cancellation of admission shall be allowed in this case; and
   iii. the ward personnel shall carry on with the absconded work process.

m. Cancellation of admission can be performed in the BDM or *Kaunter Pendaftaran Masuk Wad* as ordered by any medical personnel under the following situations;
   i. clerical error including wrong person registered, transcription error; and
   ii. in cases where patient is discharged from the ETD and admitted to the ward in the system, but has succumbed in the ETD, the patient shall be readmitted to the ETD.

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

o Despite being a fully occupied ward, patients can still be admitted by creating pseudo or virtual or flexi-bed in the HIS and physically, the ward manager shall search for extra beds.

p For the purpose of statistics required under PER PD 103, the system shall capture the time upon arrival to the ward.[6]

7.5.2 Arrival at the Ward

a An identification wristband (bar coded or printed text) shall be provided to all inpatients and shall be worn at all times during the hospital or institution stay.

b The allocation of beds for the patient shall be under the jurisdiction of the medical personnel depending on the patient's condition and availability of bed.

c Patients of the same sex (biological male or female) shall be admitted in the same room or cubicle.

d As for transgender patients, admission to the determined ward shall be according to the sex registered in the national identification card or passport and as much as possible, shall be admitted to the isolation ward, if available.[26]

e All patients shall be provided with a bed, chair, locker and hospital clothes and linen depending on the availability within the hospital or institution. Other facilities such as the toilet, bath and rest area may be shared.

f All patients who are admitted shall be given an orientation which shall include information in relation to housekeeping, ward facilities, safety instructions and information regarding data sharing (DS) through HIE platform by the ward staff.

g Patients shall also be advised against wearing jewellery or bringing along valuable items including large amounts of cash for admission.[10]

h The hospital or institution management shall have in place a system to temporarily keep the patient's belongings or valuables, when requested by the patient.

i All inpatients shall be reviewed at least once a day by doctor and as necessary, according to the patient's clinical condition.

7.5.3 Admission of Unknown Patient

a Admission or arrival of Unknown Patients such as comatose, psychiatric, amnesic and foreign patient without document etc, shall be documented into the admission book as 'unknown patient' and a registration number or MRN shall be given. In the HIS, the doctor shall enter the clinical notes in the CD or EMR.

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

c Any foreign patient without identification documents *(Pendatang Asing Tanpa Izin – PATI)* shall be reported to the relevant embassy for further action such as verification of national status, tracing the family or next of kin and subsequent deportation.[11]

7.5.4 Admission to First Class or Executive Ward

a. Patients may be admitted to First Class ward when the necessary financial circulars have been complied on a 'first come first serve' basis.

b. Decision to admit the patient to First Class shall be determined by the specialist according to the patient's clinical condition.

c. When the patient's clinical condition becomes 'unstable' and requires intensive care, the patient shall be transferred to the intensive care wards and the bed shall be vacated so that the patients in the waiting list may be admitted to occupy the bed.

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

e. Admission of Royalties or VIP shall be based on the respective state national protocol.

7.5.5 Dangerously Ill List Patient

The medical officer or specialist in charge of all patients deemed seriously ill shall be responsible for communicating the information to the relatives or next of kin in a tactful manner that is clearly understood by them.[12] Documentation of this shall be recorded in the patient's case notes or CD.

7.6 INPATIENT

7.6.1 Hand Over Communication

a. All patient report handovers shall be conducted by the nursing staff at the change of every shift duty, and the handover shall be thoroughly documented.

b. For specific guidelines, please refer to the policies of each individual department, division, or unit.

7.6.2 Terminally Ill Patient

a. All terminally ill patients in the ward shall receive care from the Palliative Care team the best possible symptom management and to ensure a dignified end of life.

b. Any relative, next of kin or any significant person of the dying patient may accompany them and shall adhere to the guidelines outlined in the Palliative and Supportive Care policy.

7.6.3 Withholding Resuscitation and Withdrawal of Intensive Therapy

The withholding resuscitation and withdrawal of intensive therapy shall be as the following:[13]

a. both preservation of life and quality of life shall be considered when making decisions in withdrawing life-sustaining treatments;

b. the life-sustaining treatments may be necessary to permit full evaluation of the patient's condition and such therapy shall not be withheld during evaluation;

c. when the patient fails to respond after a period of aggressive therapy, and it is deemed that further treatment is not only futile, but prolongs death for the patient and suffering for the family, then serious consideration shall be given to initiating withdrawal of intensive therapy;

d. the decision to withdraw therapy shall be a joint decision between the following persons:
   i. Primary team specialist;
   ii. ICU specialist in charge of the patient; and
   iii. Consultant of the Department of Anaesthesia and Intensive Care.

e. the minutes of the discussion on the decision to withdraw therapy shall be documented in the patient's medical record and consent shall be obtained;

f. the removal of life support from the patient shall not be regarded as an abandonment of the patient by the healthcare team; and

g. this policy shall also be applicable to patients receiving life support in conventional wards due to the unavailability of intensive care beds and in this situation, the joint decision shall be in between the following persons:
   i. Primary team specialist;
   ii. Family member; and
   iii. Anaesthesiologist or Emergency Physician (if applicable).

7.6.4 No Active Resuscitation

a. When any patient, suffering from incurable life threatening conditions, reaches a stage in his or her illness where further active medical or surgical interventions are deemed futile by the healthcare team in charge of the patient's care, it shall then be appropriate to consider refraining from further active interventions such as intubation, ventilation and cardiopulmonary resuscitation allowing natural death to occur in the event of cardio-respiratory arrest in such a patient.[12]

b. Although a patient may be at the end of life and that further treatment has been deemed futile by the treating healthcare team resulting in a No Active Resuscitation (NAR) status;
   i. this shall not mean that the healthcare team have no further responsibility to provide care to the patient; and
   ii. the treating healthcare team shall be fully responsible for the care, comfort and dignity of the patient as well as the family to ensure that in the midst of a crisis where all medical therapy is futile, a supportive and caring environment is still being provided with clear lines of communication and empathy being expressed.

7.6.5 End of Life Care

a. The care providers shall recognise the likelihood that death may occur soon and shall communicate this sensitively to the family and significant others.[14,15]

b. When continuing intensive care is deemed medically futile (brain death), end-of-life care shall be considered and this decision shall be discussed with the patient's family and with the other team members as appropriate.

c. The terminally ill patient and family shall, as much as possible, be involved in all decisions pertaining to treatment and preferences of care for the patient.

d. The care providers shall explore the needs of the terminally ill patient and family and shall attempt to meet their needs as far as possible.

e. Individualised plan of care which includes food and drink, symptom control and psychological, social and spiritual support shall be agreed upon, coordinated and delivered with compassion.

f. The values, religion and cultural preferences of the terminally ill patient and family shall be respected.

7.6.6 Organ Donation

Organ donation may be considered and any arrangement or matter relating to organ donation shall be referred to the Tissue and Organ Procurement (TOP) Team of the respective hospital or institution.[27]

7.7 DISCHARGE

7.7.1 Planned Discharge

a. The medical officer or specialist in charge of the patient shall be responsible for communicating information in relation to planned discharge not less than 24 hours in advance.

b. Identification wristbands shall be removed at discharge (departure) except for newborn and paediatrics cases.

c. Ward nurses shall ensure only parents/legal guardians are allowed to take discharged children home. Only parents are allowed to take home discharged babies/newborns.

d. All patients deemed fit for discharge shall be provided with prescription and relevant information about their medication prior to discharge. The function of creating a preliminary discharge summary is available in the HIS.

e. A diagnosis or multiple diagnoses shall be entered into the HIS before a patient is discharged.

f. Doctors shall complete the discharge summary within 72 hours of discharge.

g. For multidisciplinary care patients, a combined discharge summary shall be created in HIS.

h. Upon discharge, all patients, including those discharged against medical advice shall be provided with relevant documents related to their admission, follow-up and further management which shall include but not limited to the following:
   i. discharge note;
   ii. medical certificate;
   iii. appointment card;
   iv. referral letter with a copy of blood result and diagnostic imaging report (if required); and
   v. medications and prescription slip if required.

i. All clinically discharged patients must settle their bill and an official receipt shall be issued.[16,17,18,19,20,21]

j. Any patient of Malaysian citizens who are unable to settle their bill due to financial reasons shall be referred to the Medical Social Department or Revenue Unit or hospital or institution administration.

7.7.2 Discharge Against Medical Advice

a. All patients requesting to be Discharged Against Medical Advice (DAMA) may do so after obtaining adequate explanation and clarification from the medical officer or specialist in charge.[22]

b. The DAMA discharge form may be generated from the HIS and shall be completed by the medical officer in charge and signed by the patient or relatives or legal guardian and a witness.

c. DAMA for patients below the age of 18 years shall not be allowed as stipulated in the relevant circular as per the Child Act (Amendment) 2016.[5]

d. Any child whose parents or legal guardians request premature discharge (DAMA) shall be thoroughly assessed and reviewed by a specialist; and the parents or legal guardians or both shall be appropriately counselled.

e. If the refusal of care persists, the consultant or head of department or Hospital or Institution Director shall be involved in the process of decision making and all discussions shall be documented in the case notes.

f. If the child is medically fit for discharge, the healthcare staff shall arrange for appropriate early review and shall provide any necessary outpatient treatment.

g. If the child is not medically fit for discharge, but clinically stable, the healthcare staff shall offer to facilitate a transfer to an alternative healthcare facility and other forms of support or assistance such as accommodation or social support and financial assistance through the Medical Social Worker.

h. If the child is not medically fit for discharge with a high risk of morbidity or mortality should treatment be discontinued, the specialist in charge shall involve the Protector to invoke the provisions of the Child Act (Amendment) 2016.

7.7.3 Absconded Patient

a. All patients shall not be permitted to leave the ward without any authorisation and any patient departing without permission will be marked as 'absconded.'

b. If a patient is suspected or discovered missing from their ward or bed, immediate efforts shall be taken to locate them within the hospital or institution vicinity. The ward staff shall also promptly inform the next of kin.

c. If the patient remains missing, an immediate report shall be filed with the police.

7.7.4 Automatic Discharge from System

a. The system shall automatically discharge patients from the clinic at 12.00 AM.

b. For inpatients, a similar function shall be available for those discharged on the same day.

7.7.5 Discharge of Deceased Patients

a. If the HIS system is linked with the Forensic system, deceased patients shall be transferred to the mortuary and discharged from there.

b. If the HIS is not linked with the Forensic system, the deceased patients shall be discharged from the ward, and their bodies released to the mortuary.

c. Registration shall then be completed at the mortuary, either in the Forensic system or manually.

7.7.6 Discharge Diagnosis

a. Upon discharge from the hospital or institution, discharge diagnoses shall be recorded in the HIS and shall be documented as free text.

b. They shall be classified into principal and secondary diagnoses and shall be in accordance with MyCMX guidelines.

7.7.7 Referral and Discharge to Other Hospitals or Institutions

a Reasons for referral or discharge to other hospitals or institutions may include the following:
   i. **Step-up care:** Patients are transferred to another doctor or hospital or institution with superior expertise or facilities for their treatment (higher level of care);
   ii. **Same level care:** Temporary transfer due to a lack of resources (beds, personnel, equipment, medications, etc.) at the referring hospital or institution; and
   iii. **Step-down care:** Continuation of care, rehabilitation, convalescence, long-term treatment or referral back after stabilisation.

b In Hospital Cluster services, patients are typically discharged to step-down facilities. However, discharge from a facility to a higher level of care (step-up) is also available.

7.7.8 Discharge Database for HIS

In the HIS, discharge datasets shall include but not limited to the following:

a discharge home;

b Discharge Against Medical Advice (DAMA);

c discharge absconded;

d discharged to step down care; and

shall be updated with advancement in services and technology from time to time.

7.7.9 Cancellation of Discharge

a Discharge cancellation before 12.00 AM may be allowed under the following conditions;
   i. clerical error, such as discharging the wrong person or transcription error;
   ii. unexpected change in the patient's condition; and
   iii. lack of transportation or no one available to take the patient home.

b Authorised personnel in the ward shall handle the cancellation process.

7.8 DEATH

7.8.1 Inpatient Death

a Death in hospital shall include ward death and death in the department.

b Interpretation;
   i. ward death is defined as death of a patient in a hospital ward where the patient has been registered.
   ii. death in the department (DID) is defined as death of a patient in the ETD where the patient has presented to, with signs of life, registered and died after that.

c DID cases with unknown cause of death may be categorised as a sudden death and a police report shall be made.

d Pronouncement of death in the ward and ETD shall be carried out by the attending doctor.

e For **non-medicolegal cases** i.e. deaths that are not reportable to the police, the doctor of the primary team shall certify the cause of death and shall be wholly responsible for ensuring that all particulars filled in the related death registration forms are true, correct and complete, based on the available documentary evidence.

f For **medicolegal cases** i.e. deaths that are reportable to the police, the attending doctor shall not certify the cause of death in the ward unless instructed to do so by the mortuary in the event a post-mortem examination is not required by the investigating police officer.

g Should the relevant death registration forms be improperly or incorrectly filled (including the cause of death), the mortuary shall not release the dead body to the claimant until all the necessary corrections have been made by the responsible doctor.

h Upon the pronouncement of death for **non-medicolegal cases**, the ward or ETD staff shall verify the decedent organ donor status, complete the necessary last office, and notify the death to the mortuary and next of kin.

i Upon the pronouncement of death for **medicolegal cases**, the ward or ETD staff shall verify the decedent's organ donor status, complete the necessary last office, lodge a police report, and notify the death to the mortuary and next of kin.

j For any dead, if the next of kin cannot be contacted, the ward or ETD staff shall seek police assistance.

k The ward and ETD staff shall notify all deaths to the mortuary as soon as practicable after the pronouncement of death has been made.

l All unnatural, sudden and suspicious deaths are reportable to the police, such as the following:

Death	Explanation	Examples
 **Deaths related to suicide**	Deaths caused by self-harm, whether intentional or unintentional.	Drug overdose, poisoning, delayed death from hanging, or found hanging in the ward.
 **Deaths, related to accidents**	Deaths resulting from unexpected events or mishaps.	Motor vehicle accident, falls from height, falls at home, falls in the ward, secondary drowning, sports injury and all other forms of accidents.
 **Homicidal deaths**	Deaths caused by deliberate harm inflicted by another person.	Victim of an assault or intentional killing.
 **Deaths related to animals**	Deaths caused by interactions with animals, either through attacks or stings.	Death from bee sting, snake bite or dog bite.
 **Iatrogenic deaths**	Deaths where medical treatment or procedure is suspected to have contributed, raising concerns about potential medical negligence.	Deaths where there is suspicion or allegation of medical negligence.
 **Custodial deaths**	Deaths occurring while the person is in custody, regardless of whether the cause is natural or unnatural.	Irrespective whether due to natural or unnatural causes, including deaths in the psychiatric wards.[28]

m. The ward or ETD staff shall comply without reservation to any instructions given by the mortuary regarding the notification of reportable deaths to the police.

n. All the dead bodies may only be transferred to the mortuary after one (1) hour following the pronouncement of death and shall never be allowed to remain too long in the ward to prevent early decomposition, irrespective whether the clinical cause of death is known or unknown or whether the next of kin is available for notification of death.

o. All dead bodies shall be released to the next of kin or authorised claimant through the mortuary and for any special exemption to release the body through the ward may only be authorised by the Hospital or Institution Director.[23,24]

p. For unexplained hospital deaths that are not categorised as reportable cases to the police, the doctor of the primary team may request for a clinical post-mortem examination if necessary.

q. All deaths of biohazard cases shall be handled in accordance with the established standard and procedures to prevent cross infection.

r. In the event of a death during transfer, in the absence of an accompanying doctor, the ambulance shall make for the nearest hospital to confirm death by a doctor.

s. Pursuant to paragraph (r), the ambulance shall then return to its base and shall not proceed to its referral hospital or institution with the deceased.

7.8.2 Brought In Dead

a. Brought In Dead (BID) is defined as death of a patient who is brought to the ETD with no signs of life or a person who is BID to the mortuary by the police.

b. BID cases shall only have the time when the cardiopulmonary resuscitation efforts are stopped and not the approximate time of death.

c. The time at which the body is registered shall be used as the time of death.

d. Sudden deaths for patients who are not registered as ward patients in the outpatient facilities such as the specialist clinics, diagnostic imaging department and blood donation unit, shall be categorised as BID cases and shall be sent to the ETD as BID cases and shall be reported to the police.

e. Should there be any discrepancies detected in terms of designation of death by the ETD as BID or DID, the Forensic Medicine Department or Unit shall seek clarification and request necessary corrections be made by attending clinicians.

f. All BID cases brought by the police shall be sent directly to the mortuary.

g. BID cases brought by the next of kin or public to the ETD shall be reportable cases to the police and a sudden death police report shall be made by the ETD staff before transferring the body to the mortuary.

h. The cause of death for the BID cases shall not be issued by the ETD doctors.

7.8.3 Forensic Post-mortem Examination

a. The requirement for any forensic post-mortem examination shall subject to the requirements of police investigation and shall never at the discretion of clinicians.[25]

b. A forensic post-mortem examination shall not require any form of consent from the next-of-kin.

c. Any clinician or pathologist shall not authorise a forensic post-mortem examination.

d. The extent of the post-mortem examination shall be decided by the prosecuting doctor and a complete autopsy shall be performed whenever practicable.

e. A forensic post-mortem examination shall be performed without exception once a post-mortem order *(Surat Polis 61)* has been received from the investigating police officer, unless the order is subsequently withdrawn by the police.

f. A forensic post-mortem examination shall be performed at the soonest time that is deemed practicable for the particular case.

g. A hospital or institution staff, irrespective of grade and position, shall not interfere or obstruct a forensic post-mortem examination and the failure to comply may be construed as an unjustifiable criminal attempt to obstruct a public servant from discharging his or her duties and a police report may be lodged accordingly.

h. If a forensic post-mortem examination is not required by the police for a particular medicolegal hospital death, the attending ETD doctor or the doctor from the primary team may certify the clinical cause of death.

i. Subject to paragraph (h), in the event where the cause of death cannot be clinically ascertained, the police may either reconsider the need for a post-mortem examination or the police himself may certify the cause of death for the purpose of body disposal and death registration.[15]

7.8.4 Clinical Post-mortem Examination

a. Clinical post-mortem is a post-mortem examination that is performed on a hospital death which is requested by clinicians and a written informed consent from the next of kin shall be mandatory.

b. Cases involving clinical post-mortem shall not involve police investigation and shall not be consented by the clinicians or pathologists

c. Clinical post-mortem examinations shall be under the purview of anatomical pathology.

d. For unexplained hospital deaths that are not categorised as reportable cases to the police, the attending doctors may request for a clinical post-mortem examination if necessary.

e. The anatomical pathology team shall ensure that the requesting clinician has obtained a proper written informed consent for the clinical post-mortem examination from the next of kin.

7.9 MANAGEMENT OF PATIENT BELONGINGS

a. The hospital or institution shall not be responsible for any personal belongings of patients or visitors, including items left in patient wards.

b. Similarly, the hospital or institution shall not be liable for any loss, theft, or damage to personal belongings.

c. Whenever possible, hospital or institution staff shall release the patient's personal belongings to the patient's family or relatives when the patient is unable to manage them.

d. Patients and relatives shall be advised not to bring valuables or cash during admission, and any such items shall be sent home with family members.

e. For unconscious patients, the hospital or institution shall safeguard belongings until they recover or can be handed over to relatives.

f. Efforts shall be made as much as possible to hand over these belongings to the nearest relatives after verification.

g. In special cases, such as when a patient passes away or no relatives can be contacted, belongings shall be managed according to guidelines.[10]

7.10 PATIENT SAFETY AND SECURITY

Ensuring patient safety and security shall be a fundamental component of delivering high- quality healthcare. The hospital or institution shall promote a proactive approach that fosters a strong culture of patient safety.[29]

a. **Absconded Patients**
Protocols for absconded patients are outlined in Section 7.7.3. The hospital shall ensure that these procedures are effectively implemented across all relevant areas. This includes prompt response actions, documentation of the incident, and timely communication with relevant authorities.

b. **Mentally Unstable Patient**
The hospital or institution shall adopt early identification, timely referral, and consistent monitoring protocols for patients with mental health instability. These measures aim to enhance patient safety, improve clinical outcomes, and support recovery.[30]

c. **Newborn Safety**
To ensure the safety of newborns from birth to discharge, the hospital or institution shall establish comprehensive newborn security measures, including:

i. infant identification tagging;
identification tags shall be prepared prior to delivery and securely attached to newborns immediately after birth.

ii. discharge verification;
discharge procedures shall include thorough identity verification and security screening at the exit points.

iii. security infrastructure;
robust security systems shall be maintained, including visitor identification protocols, continuous surveillance, and the presence of trained security personnel.[31]

1 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 6, Tahun 1992 – Pengurusan Pesakit dan Waris Mereka Semasa Berada di Hospital, bertarikh 10 Disember 1992.*
2 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 8, Tahun 1987 – Keselamatan Pesakit-pesakit di Hospital-hospital, bertarikh 24 Jun 1987.*
3 *Guideline of the Malaysian Medical Council Consent for Treatment of Patients by Register Medical Practitioners, Version 3/2025.*
4 *Mental Health Act, 2001.*
5 *Child Act, Amendment 2016.*
6 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 2, Tahun 2009 – Garis Panduan Rujukan dan Perpindahan Pesakit di antara Hospital-hospital KKM, Mei 2009.*
7 *Surat Pekeliling Ketua Setiausaha KKM, Bilangan 5, Tahun 2018 – Garis Panduan Pengurusan Hospital Kluster, bertarikh 20 Disember 2018.*
8 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 6, Tahun 2001 – Penyelarasan Panduan Kemasukan Pesakit ke Hospital-hospital, bertarikh 2 April 2001.*
9 *Surat Pekeliling Ketua Setiausaha KKM, Bilangan 2, Tahun 2015 – Garis Panduan Pengurusan Kutipan Hasil Bagi Pesakit Warga Asing Yang Tidak Membayar Deposit Semasa Mendapatkan Rawatan di Hospital Kerajaan, bertarikh 4 Mac 2015.*
10 *Surat Edaran Bahagian Kewangan KKM – Pindaan Garis Panduan Menguruskan Harta Benda dan Wang Tunai Pesakit, bertarikh 9 April 2013.*
11 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 10, Tahun 2001 – Garis Panduan Melaporkan Pendatang Tanpa Izin Yang Mendapatkan Perkhidmatan Kesihatan di Hospital dan Klinik Kesihatan, bertarikh 18 September 2001.*
12 *ICU Management Protocols, 2019.*
13 *Laman sesawang Malaysian Society of Anaesthesiologist – Withdrawal and Withholding of Life Support in Critically Ill, March 2004.*
14 *Palliative Care Services Operational Policy, November 2010.*
15 *Advance Care Planning – A Guide for Healthcare Practitioners in Malaysia, August 2024.*
16 *Fees (Medical) Order 1982, (Amendment) 2017.*
17 *Fees (Medical) (Amendment) (Foreigner) Order, 2014.*
18 *Fees (Medical) (Full Paying Patient) Order, 2007.*
19 *Surat Pekeliling Ketua Setiausaha KKM, Bilangan 4, Tahun 2017 – Pelaksanaan Perintah Fi (Perubatan) (Pindaan) 2017, bertarikh 26 Januari 2017.*
20 *Surat Pekeliling Ketua Setiausaha KKM, Bilangan 2, Tahun 2019 – Garis Panduan Pelaksanaan Perintah Fi (Perubatan) (Kos Perkhidmatan) 2014, bertarikh 8 April 2019.*
21 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 2, Tahun 2015 – Garis Panduan Pelaksananaan Perintah Fi (Perubatan) (Pesakit Bayar Penuh) 2007 (Semakan 2015), bertarikh 19 Mac 2015.*
22 *Surat Pekeliling Ketua Perkhidmatan Kesihatan, Bilangan 24, Tahun 2021 – Prosedur Mengenai Pesakit Yang Ingin Discaj Dari Hospital Atas Risiko Sendiri, bertarikh 13 Disember 2021.*
23 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 1, Tahun 1998 – Garis Panduan Penggunaan Format PNM1/97 Bagi Melapor Kematian Perinatal.*
24 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 5, Tahun 2008 – Garis Panduan Penyerahan Mayat-mayat Yang Tidak Dituntut di Hospital KKM kepada Fakulti Perubatan Universiti Tempatan bagi Maksud Pendidikan dan Penyelidikan Perubatan, bertarikh 5 Mei 2008.*
25 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 10, Tahun 2012 – Standard Operating Procedures of Forensic Medicine Services, bertarikh 22 Februari 2012.*

26 *Surat JAKIM – Ulasan Berkaitan Golongan Lesbian, Gay, Bisexual dan Transgender (LGBT) yang Menggunakan Perkhidmatan Hospital KKM, bertarikh 12 Mei 2023.*

27 *National Organ, Tissue and Cell Transplantation Policy, June 2007.*

28 *Psychiatric and Mental Health Services Operational Policy, 2011.*

29 *Malaysian Patient Safety Goals 2.0: Guideline on Implementation and Surveilance, 2021.*

30 *Guideline on Suicide Risk Management in Hospitals, 2014.*

31 *Garis Panduan Sistem Kawalan Keselamatan Bayi di Hospital-hospital Kementerian Kesihatan Malaysia, Edisi Kedua, Tahun 2024.*

CHAPTER

08 CLINICAL GOVERNANCE


HOSPITAL
SEBERANG JAYA

08 Clinical Governance

8.1 PROCEDURES AND SURGERY

a. Each procedure or surgery planned shall be documented in the patient's case notes and referral to the Anaesthetic Clinic shall be encouraged prior to elective surgery.[1]

b. All consents shall be taken using the consent form prior to the procedure or surgery.

c. Efforts shall be made to ensure safe surgery which shall include the following: [2]

   i. The right patient;
   ii. The right procedure; and
   iii. The right site.

d. Upon arrival at the Operation Theatre (OT), the OT nurse shall verify with the relative or patient regarding the following based on a checklist:

   i. Patient's details;
   ii. Consent;
   iii. Type of operation; and
   iv. Site of operation.

e. The procedure or surgery performed shall be recorded using a prepared format and attached to the patient's case notes.

f. In HIS hospital, the procedure or surgery performed shall be entered into the integrated HIS or equivalent.

g. Documentation shall include;

   i. the post-operative diagnosis;
   ii. a description of the surgical procedure;
   iii. findings;
   iv. any surgical specimen sent;
   v. the name of the surgeon and assistants; and
   vi. patient post-operative care plan.

h. Patient post operative care shall include adequate postoperative pain management.[3,4]

i. All mortalities involving surgeries shall be reported in accordance with Perioperative Mortality Review (POMR) requirements and shall involve the POMR Committee.[5]

8.2 DRUGS AND MEDICATION

8.2.1 Patient Own Medication

a. Patients shall bring their own medications if admitted and the medications shall be dispensed during admission.

b. The usage of patient own medication shall depend on the patient's clinical condition and advice from the attending doctor.

c. The staff receiving the patient own medication shall inspect the condition of the medications, record in the Medication History Assessment Form, Form CP1, and manage the medications to prevent any medication error.

d. The medications shall be labelled clearly to identify the name of the medication and the patient's registration number.

e. Patients shall not be allowed to consume the medications without permission from the attending staff.

f. The medications shall be returned to the patients prior to discharge if the regime is still needed.

g. If during admission, the medication regime has changed, the medications shall be returned to the pharmacy or to the patient, if they are self-purchased.

8.2.2 Usage

a. The hospital or institution drug formulary shall be maintained and shall be used as a guide for drug prescription.

b. Medicines which are not listed in the hospital or institution drug formulary but available in the MOH's Medicines Formulary (Blue Book) shall require the respective specialist or head of department's approval.

c. Medicines not listed in the Blue Book shall require special approval from the Director General of Health.

d. The respective HOD shall be responsible for justifications of drug usage and cost implication and the requests for approval shall be made using specified format and submitted through the director's office.

8.2.3 Prescription

a. Doctors shall only prescribe drugs to registered patients.

b. Prescriptions performed in the Pharmacy system i.e. the Pharmacy Information System (PhIS) KKM need not be transcribed in the physical notes, as the date and time of prescription shall be captured in the system.

c. Prescriptions referred by the Pharmacy Department from other MOH hospitals and clinics shall be accepted.

d. Prescriptions from *Institut Jantung Negara* (IJN) for a registered MOH patient shall be endorsed by the hospital or institution's specialist before prescription is filled, subject to the availability of drugs.

e. Prescriptions from the private sector shall not be accepted.

f. Prescription for more than one (1) month shall be filled in at specified intervals and the patients shall be required to collect their medicines within one (1) week of the date of prescription.

8.2.4 Dispensing

a. Drugs shall be dispensed at the specified pharmacy counter except for discharged patients.

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

c. Bedside dispensing, as much as possible, shall be carried out for discharged patients.

d. Any urgent needs for medication after office hours for inpatients shall be met by the hospital or institution's pharmacy staff on call.

e. Value Added Services (VAS) may be established to reduce congestion at the outpatient counter of the hospital or institution but shall depend on the capacity of the hospital or institution.

f. Other initiatives including dispensing of list A drug using the *Sistem Pendispensan Ubat Bersepadu* (SPUB) form may also be implemented.

8.2.5 Monitoring

a. The usage of drugs, prescriptions and drug reaction shall be monitored by the Pharmacy Department.

b. A Drug Therapeutic committee shall be established to coordinate, monitor and manage all issues relating to drugs and drug usage.[6]

8.3 INFECTION PREVENTION AND CONTROL

8.3.1 Sterilization and Disinfection

a. The Centralised Sterile Supply Unit shall be responsible for the overall sterilisation and disinfection services in the hospital or institution.[7,8]

b. The sterilisation and disinfections of equipment and surgical items shall be carried out using the MOH approved disinfectant through the appropriate and accepted technique or method.

c. All staff involved in the sterilisation process shall follow the standard procedures to ensure the sterility of the product.

d. All staff shall wear proper attire for safety protection against infection and other hazards.

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

f. The sterilisation of delicate equipment shall be carried out by trained staff using appropriate technique.

g. Soft dressing shall be pre-packed and sterilised centrally.

h. For high-risk patients, such as known cases of HIV/AIDS and Hepatitis B, disposable sets shall be used.

8.3.2 Infection Control

a The hospital or institution shall establish the Hospital Infection and Antibiotic Control Committee (HIACC) which shall have an advisory, planning, coordinative and supervisory role on the Infection Control and Antimicrobial Resistance Containment Programme.[9,10,11]

b The main role of HIACC shall include the following;

i. formulate and review policies and procedures regarding healthcare associated infection and the control of antimicrobial resistance (AMR);
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 healthcare workers and where applicable, patients, relatives and visitors;
iv. plan out hospital-wide infection control programmes and activities yearly which shall be incorporated in the day-to-day activities of personnel, patients, and visitors;
v. monitor the trend of infection control, antimicrobial resistance and antibiotic consumption surveillance data and advise on the remedial actions or quality improvement measures; and
vi. provide guidance in the management of outbreak in the hospital or institution.

8.3.3 Antimicrobial Resistance Containment

a A Hospital Infection and Antibiotic Control Committee (HIACC) shall be established to monitor and coordinate all activities related to infection control and Antimicrobial Resistance (AMR) containment.[10,12]

b All issues pertaining to infection in the hospital or institution and AMR shall be presented to the Committee for further action.

c The hospital or institution shall establish the Infection Control Unit or team with appropriate staffing which, in general, shall include the Medical Officers and Infection Control staff based on the standard norms.

d The Infection Control Unit or team shall consist of the following:

i. An Infection Control Doctor as a coordinator;
ii. Infection Control Medical Officers; and
iii. Infection Control trained staff,

who shall work with the liaison officers (link nurses) from each area or ward in their day-to-day duties.

e The Infection Control Unit or team shall monitor the implementation of infection control procedures, carry out surveillance activities and audit activities, monitor healthcare associated infection and healthcare associated multidrug resistant organisms and conduct training of hospital staff.

f The hospital or institution shall establish the Antimicrobial Stewardship (AMS) team to carry out the AMS activities to ensure judicious use of antimicrobials.[13]

g The AMS team shall at least consist of an infectious disease physician or physician, clinical pharmacist, clinical microbiologist or microbiologist and trained Infection Control staff.

h. Whenever possible, AMS team shall do the AMS round in targeted wards and provide comments and any recommendation on the antibiotic prescribed by the officers.

i. All notifiable infectious diseases shall be notified through the *e-Notifikasi* application under the Communicable Disease Control Information System (CDCIS) and where applicable, the HIS and *e-Notifikasi* or any current or future system as advised by the Disease Control Division which shall be integrated for efficient reporting.

j. The AMS team shall monitor the AMR pattern and antibiotic consumption pattern and present them to the HIACC.

k. The hospital or institution shall establish an Outbreak Management Team whenever there is a major outbreak in the hospital or institution.

l. All outbreaks shall be notified to the State Health Office, District Health Office, National Crisis Preparedness and Response Centre (CPRC) and Medical Development Division (CPRC of Hospital Services).

m. An outbreak management plan shall be developed based on local policy and consultation between the infection control professionals, healthcare workers, facility management and state or territory health authorities, as appropriate.

n. All notifiable infectious diseases shall be notified to the District Health Office and shall be in accordance with the existing Acts or Regulations.

o. Infectious patients with novel infection, multidrug resistant organism or airborne infection shall be placed and nursed in an isolation room, wherever possible.

p. Notwithstanding paragraph (o), the use of multi-bedded rooms for the same type of infection shall be acceptable.

q. All staff shall be instructed to adhere to standard precautions and transmission-based precautions guidelines at all time.

8.3.4 Wound Care

a. The hospital or institution shall establish the Hospital Wound Care Committee (HWCC) which has an advisory, planning, coordinating and supervisory role on the management of complicated wounds.[14,15]

b. The hospital or institution shall establish the wound care team to carry out the day-to-day wound care activities to ensure the holistic patient care approach in the management of wounds.

c. The main role of HWCC and Wound Care Team shall include the following:
   i. Disseminate knowledge, improve skills and inculcate desired values in health care workers about the subject through education and training; and
   ii. Plan out hospital-wide wound care programmes and activities yearly which shall be incorporated in the day-to-day activities.[6]

8.4 HEALTH EDUCATION

a. The hospitals or institutions shall provide effective health or patient education services to support patient care, with such services shall be made available through the system in HIS hospitals or institutions.

b. The Health Education Department or Unit, if available, shall plan, coordinate, implement, monitor and evaluate all activities related to health or patient education programs in line with current MOH policies.

c. Notwithstanding paragraph (b), all hospitals and institutions shall be encouraged to organise talks and exhibitions aimed at providing health education to the public.

d. Additionally, health promotion activities shall be arranged to raise public awareness and promote community involvement.

8.5 ORGAN, TISSUE DONATIONS AND TRANSPLANTATION, BLOOD DONATION

a. All state and major specialist hospitals or institutions shall establish the Hospital Transplantation Technical Committee to support and monitor all organ donation and tissue procurement activities.

b. The MOH has identified 16 focus hospitals or institutions to establish the *Unit Perolehan Organ Hospital* (UPOH) involving 13 states except for the state of Perlis. Concurrently, TOP teams shall be established in other Type 1 and/or Type 2 hospitals or institutions.

c. The UPOH and TOP team shall be responsible for;
   i. identification and management of potential donors including evaluation for donation, family counselling and obtaining informed consent from the next of kin; and
   ii. organ or tissue procurement coordination which shall incorporate communication with the National Transplant Resource Centre (NTRC) to ensuring appropriate organ and/or tissue storage and transport.

d. All UPOH and TOP team activities shall be reported to the Hospital or Institution Director.

e. All potential cases for cadaveric donations shall be made known to the local UPOH and TOP Team.

f. All deaths shall be considered for possible donations.

g. In the case of living organ donations, all potential cases of;
   i. unrelated living organ donation;
   ii. organ donor-recipient pair involving non-Malaysian; and
   iii. donor-recipient pair with undetermined relationship,

   shall undergo assessment and evaluation by the Unrelated Transplant Approval Committee.

h. Policies and procedures shall be made available to guide the procurement, donation process and transplantation of organs and tissues and shall be consistent with the relevant laws and regulations and respect the community values, spiritual beliefs and religion.[16,17,18,19]

8.6 ETHICS AND LAW

a. The hospital or institution shall abide by the laws of the country, policies and guidelines of the MOH, medical ethics and relevant policies and guidelines of other Ministries.

b. Legislations, regulations, policies and guidelines may be amended by the relevant authorities as and when necessary.

1 *Anaesthetic Clinic Protocols, November 2012.*
2 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 4, Tahun 2018 – Guidelines on Safe Surgery Saves Lives Programmes, 2nd Edition, 2018, bertarikh 20 September 2018.*
3 *Pain as The 5th Vital Sign Guideline, 3rd Edition, 2018.*
4 *Implementation of Perioperative Mortality Review (POMR) Guideline in the Ministry of Health Malaysia (3rd Edition), July 2022.*
5 *Garis Panduan Pengisian Borang VPOMR, Edisi Ke–2, Julai 2022.*
6 *Tatacara Pengendalian Mesyuarat Jawatankuasa Ubat & Terapeutik di Fasiliti Kementerian Kesihatan Malaysia, Edisi 2, Tahun 2024.*
7 *Central Sterile Supply Service Policy, 2018.*
8 *Disinfection Guidelines, 2nd Edition, 2019.*
9 *Policies and Procedures on Infection Prevention and Control, 3rd Edition, 2019.*
10 *Malaysian Action Plan on Antimicrobial Resistance (MyAP–AMR), 2022 – 2026.*
11 *Prevention and Control of Infectious Diseases Act, 1988.*
12 *International Health Regulations (IHR), 2005.*
13 *Protocol on Antimicrobial Stewardship (AMS) Programme in Healthcare Facilities, 2nd Edition, 2022.*
14 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 10, Tahun 2011 – Garis Panduan Pelaksanaan Penubuhan Pasukan Penjagaan Luka di Hospital-hospital KKM.*
15 *Wound Care Manual, 2nd Edition, 2023.*
16 *National Organ, Tissue and Cell Transplantation Policy, June 2007.*
17 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 1, tahun 2012 – Garis Panduan Pendermaan Organ dari Penderma Hidup Tiada Kaitan Kekeluargaan, bertarikh 4 Januari 2012.*
18 *Unrelated Living Organ Donation – Policy and Procedures, 2011.*
19 *Surat Pekeliling Ketua Pengarah Kesihatan Malaysia, Bilangan 5, Tahun 2019 – Pengukuhan Tadbir Urus Perkhidmatan Perolehan Organ dan Tisu Kementerian Kesihatan Malaysia, bertarikh 19 Jun 2019.*


HOSPITAL
SULTAN IDRIS SHAH
SERDANG

CHAPTER

09 DISASTER MANAGEMENT


HOSPITAL SULTANAH BAHIYAH

09 Disaster Management

9.1 DISASTER PLAN AND EMERGENCY PREPAREDNESS

A disaster plan and emergency preparedness are essential for ensuring that individuals and organisations are able to respond effectively to unexpected emergencies, such as natural disasters or crises. These plans outline specific actions, resources, and communication strategies to minimise damage, protect lives, and ensure a quick recovery.[1]

a. A Disaster Management Committee or equivalent, chaired by the Hospital or Institution Director, shall oversee disaster preparedness.

b. The committee members shall include clinicians, department or unit representatives, and privatised support service representatives.

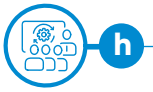
c. The committee shall;
   i. be responsible for developing and implementing the Disaster Management Plan, Hospital Contingency Plan, and Business Continuity Plan for IT system downtime and regular meetings shall be held to address issues and implement solutions; and
   ii. develop disaster preparedness plans for various events such as fire, flood, earthquakes, bomb threats, chemical or biological threats, mass casualty incidents and others.

d. Input from departments like the ETD, Public Health Unit, Infection Control Unit and others shall be considered in disaster preparedness planning.

e. Disaster preparedness plans, including BCP affecting the systems, shall be communicated to all staff.[2,3,4,5,6]

f. In the event of a disaster, the Director shall declare a red alert and activate the Disaster Management Plan.

g. The Disaster Management Plan shall include the following:
   i. Emergency alert systems;
   ii. Designated posts and responsibilities;
   iii. Medical teams;
   iv. Victim management; and
   v. Documentation and statistics.



h. All staff shall receive training on the Disaster Management Plan, including the use of special equipment, patient transportation, and evacuation procedures.

i. Regular disaster drills shall be conducted at least once a year and shall be evaluated.

j. The department and unit heads shall be responsible for developing and implementing the disaster plan for their respective areas.

9.2 HOSPITAL EVACUATION

a The hospital or institution shall have an evacuation plan in place.

b All staff shall be briefed on the evacuation plan, including exit routes and assembly areas.

c Exit route plans shall be prominently displayed in all departments, units and wards, including assembly areas.

d Evacuation drills shall be conducted at least once a year.

9.3 SPECIFIC CONTINGENCY PLANS

a Specific contingency plans shall be developed for various situations including the following;
i. power failures, IT system breakdowns;
ii. water supply disruptions;
iii. gas leaks;
iv. floods;
v. disease outbreaks;
vii. air condition failure;
viii. building infestation;
ix. earthquake or other natural disease;
x. tele-communication failure (PABX Shutdown);
xi. fire hazards/*Mencegah Bahaya Kebakaran* (MBK); and
xii. building renovation and service closure.

b The plans shall outline notifications, responsibilities, immediate actions, alternative solutions, and follow-up measures.

c All staff shall be briefed on these plans, and appropriate training shall be provided.

9.3.1 Fire Safety

a The hospital or institution shall appoint a fire safety officer and prepare a fire contingency plan.[7]

b Appropriate and adequate fire equipment or extinguishers shall be made available in all areas and regularly maintained.

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

d Fire retardant doors shall be kept closed at all times but not locked.

e If exit doors need to be locked, the keys shall be made readily available.

f In the event of a fire, the patients shall be evacuated in accordance with the principle of horizontal evacuation, and if the fire continues to spread, the patients shall move vertically down.

g All staff shall receive training on fire safety, evacuation procedures and use of firefighting equipment.

h Fire drills shall be conducted regularly, at least once a year.

9.3.2 Radiation Protection

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

b. Policies and procedures pertaining to radiation safety and protection shall be made available to all the relevant departments and units.[8-14]

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

d. Staff exposed to radiation shall have their blood count checked regularly and undergo necessary medical examination.

9.4 SECURITY

a. The different areas in the hospital or institution shall be identified as high, medium and low security which shall include but not limited to high-security areas such as the entrances, stores, revenue unit, wards, delivery suites, Haemodialysis Unit and IT Unit inclusive of server rooms and telecommunication rooms.[15-18]

b. Areas identified as high or medium security shall have security measures installed such as limited access doors or security guards placed full-time or both. Other areas shall have a regular site patrol by the security guards.

c. Risk assessment shall be done periodically to determine level of security measures in certain areas and shall include areas with different needs of proof if incidents vary.

d. Clear and appropriate signs shall be placed in areas and on doors to the rooms, which are restricted for the staff or authorised personnel only and areas of patients, relatives and visitors.

e. The department or unit heads shall be responsible for the security procedures within the department and shall ensure their staff compliance with the procedures.

9.5 SAFETY

a. The hospital or institution management shall be responsible for ensuring a conducive environment within the hospital or institution to support staff in achieving organisational goals.

b. An Occupational Safety and Health (OSH) Committee shall be established within the hospitals or institutions to oversee safety regulations and minimise risks for patients, staff, visitors and contractors.[19-21]

c. The hospitals or institutions shall maintain a safe working environment to safeguard staff, visitors, contractors and patients from potential harm and injuries, such as falls, needle prick injuries and fires.

d. Staff members shall consistently adhere to universal precautions and shall follow all guidelines related to infection control.

e. Any cases relating to the Notification of Accident, Dangerous Occurrence, Occupational Poisoning and Occupational disease (NADOPOD) Regulations 2004 shall be promptly reported as per protocol.[22]

f. All staff shall be required to inform the liaison officer in charge of safety at the respective department or unit of any situations or environments within the hospital or institution premises that could pose risks to staff and patients.[23]

1 *Panduan Pelan Tindakan – Insiden Kecemasan dan Bencana Dalaman Bagi Hospital-hospital Kementerian Kesihatan Malaysia, Edisi Pertama, 2019.*
2 *Event-Based Surveillance Protocol, MOH, 2018.*
3 *Malaysia Strategic Plan on Emerging Diseases (MySED) II, 2017–2021.*
4 *Panduan Penyediaan Pelan Tindakan Bencana Rekod (PTBR) Kerajaan, 2012.*
5 *Cyber Security Act, 2024 (Act 854).*
6 *Arahan NADMA No.1 Dasar dan Mekanisme Pengurusan Bencana Negara.*
7 *Hospital Fire Prevention and Evacuation Guide, PAHO, WHO, 2014.*
8 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 10, Tahun 2002 – Panduan Tatacara Pengendalian Filem X-Ray di Hospital-hospital dan Klinik Kesihatan Malaysia, bertarikh 14 Oktober 2002.*
9 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 9, Tahun 1994 – Guidelines and Action Plan on Management of Radiation Emergencies, bertarikh 28 November 1994.*
10 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 10, Tahun 1987 – Penggunaan Mesin X-Ray MMR di Hospital-hospital, bertarikh 6 Oktober 1987.*
11 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 6, Tahun 1986 – Menghadkan Penggunaan Mesin X-Ray Jenis Mobile/Portable untuk Kegunaan Radiologi di Wad-wad, bertarikh 21 Januari 1986.*
12 *Akta 304 – Akta Perlesenan Tenaga Atom, 1984.*
13 *Pelaksanaan Peraturan-peraturan Perlesenan Tenaga Atom (Perlindungan Sinaran Keselamatan Asas) 2010, bertarikh 3 Januari 2011, from Ministry of Science, Technolgy and Innovation (MOSTI).*
14 *Surat Edaran Ketua Pengarah Kesihatan – Makluman Edaran Tatacara Pelupusan Radas Penyiaran dan Peranti Yang Menggunakan Bahan Radioaktif, bertarikh 3 Ogos 2018.*
15 *Garis Panduan Sistem Kawalan Keselamatan Bayi di Hospital-hospital Kementerian Kesihatan Malaysia, Edisi Kedua, Tahun 2024.*
16 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 14, Tahun 2002 – Garis Panduan Sistem Kawalan Keselamatan di Hospital-hospital Kementerian Kesihatan Malaysia, bertarikh 20 November 2002.*
17 *Surat Pekeliling Ketua Setiausaha KKM, Bilangan 10, Tahun 2019 – Dasar Keselamatan ICT KKM Versi 5.0, bertarikh 19 September 2019.*
18 *Surat Pekeliling Am, Bil.1, Tahun 2020 – Pemakluman Pemakaian dan Penguatkuasaan Arahan Keselamatan (Semakan dan Pindaan 2017).*
19 *Occupational Safety and Health Act, 1994 [Act 514] P.U. (A) 616/1996.*
20 *Occupational Safety and Health (Safety and Health Committee) Regulations, 1996.*
21 *Occupational Safety and Health Act, 1994, Occupational Safety and Health (Notification of Accident, Dangerous Occurrence, Occupational Poisoning and Occupational Disease) Regulations, 2004.*
22 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 9, Tahun 2010 – Notifikasi Penyakit Pekerjaan & Keracunan Pekerjaan Di Bawah Peraturan Keselamatan & Kesihatan Pekerjaan (Pemberitahuan mengenai kemalangan, kejadian berbahaya, keracunan pekerjaan) (NADOPOD) 2004, untuk Pegawai Perubatan di KKM, bertarikh 26 April 2010.*
23 *Pekeliling Perkhidmatan, Bilangan 5, Tahun 2018 – Garis Panduan Pengendalian Kes Gangguan Seksual di Tempat Kerja.*

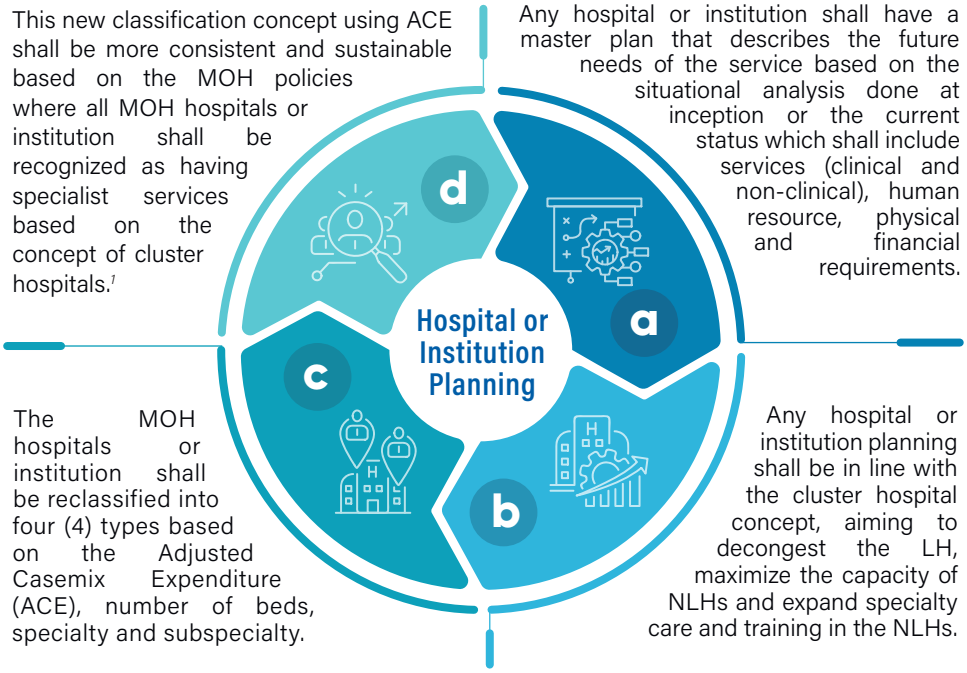
CHAPTER

10 PLANNING DEVELOPMENT


HOSPITAL QUEEN ELIZABETH II

10 Planning Development

10.1 HOSPITAL OR INSTITUTION PLANNING



This new classification concept using ACE shall be more consistent and sustainable based on the MOH policies where all MOH hospitals or institution shall be recognized as having specialist services based on the concept of cluster hospitals.[1]

Any hospital or institution shall have a master plan that describes the future needs of the service based on the situational analysis done at inception or the current status which shall include services (clinical and non-clinical), human resource, physical and financial requirements.

The MOH hospitals or institution shall be reclassified into four (4) types based on the Adjusted Casemix Expenditure (ACE), number of beds, specialty and subspecialty.

Any hospital or institution planning shall be in line with the cluster hospital concept, aiming to decongest the LH, maximize the capacity of NLHs and expand specialty care and training in the NLHs.

Hospital Type	1	2	3	4
Adjusted Casemix Expenditure (ACE) (RM million) Median (Min-Max)	≥ 500	**235** (196-499)	**74** (55-195)	**30** (5.6-54)
Number of Beds Median (Min-Max)	**1032** (630-2200)	**512** (260-760)	**137** (70-320)	**80** (8-190)
Number of Specialty and Subspecialty Median (Min-Max)	**64** (40-120)	**38** (20-60)	**19** (3-40)	**13** (1-35)

Note: ACE for each hospital shall be reviewed from time to time.

10.2 SERVICE REGIONS

a Starting from the 12th Malaysia Plans onwards, the country shall be grouped into 10 service regions.

b These regions shall be divided based on the geographical location of the hospitals or institution and existing referral and networking systems.

No.	Region	States/Districts	Cluster/Hospitals or Institutions
1.	Northern	Perlis, Kedah, Pulau Pinang, Perak.	All hospitals in Cluster Pulau, Seberang Perai, Kedah Utara, Kedah Tengah, Kedah Selatan, Ipoh, Manjung, Perak Utara, Perak Selatan. Hospital Tuanku Fauziah. Hospital Sultanah Maliha.
2.	Eastern	Kelantan, Terengganu, Pahang.	All hospitals in Cluster Pahang Timur, Pahang Tengah, Pahang Barat, Terengganu Utara, Terengganu Selatan, Kelantan Utara, Kelantan Barat, Kelantan Selatan.
3.	Central	Selangor, WP KL and Putrajaya, Negeri Sembilan.	All hospitals in Cluster Klang Valley 1, Klang Valley 2, Klang Valley 3, Klang Valley 4, Negeri Sembilan 2, HTAN.
4.	Southern	Johor, Melaka.	All hospitals in Cluster Melaka, Johor Timur, Johor Utara, Johor Barat, Johor Selatan.
5.	Eastern Sabah	Sandakan, Beluran, Kinabatangan.	All hospitals in Cluster Sandakan.
6.	Southeast Sabah	Semporna,Tawau, Lahad Datu, Kunak.	All hospitals in Cluster Tawau.
7.	Western Sabah	Kota Marudu, Kota Kinabalu, Keningau, Beaufort, Bukit Padang, Tuaran, Papar, Ranau, Kota Belud, Tenom, Tambunan, Kudat, Pitas, Kuala Penyu, Sipitang.	All hospitals in Cluster Kota Kinabalu, Cluster Kota Marudu, Cluster Beaufort, Cluster Keningau, Hospital Labuan.
8.	Northern Sarawak	Lawas, Limbang, Miri, Marudi, Bintulu.	All hospitals in Cluster Sarawak Barat & Sarawak Utara.
9.	Central Sarawak	Mukah, Dalat, Sibu, Kapit, Betong, Kanowit, Daro, Sarikei, Saratok.	All hospitals in Cluster Sarawak Timur & Sarawak Tengah.
10.	Southern Sarawak	Serian, Bau, Kuching, Sentosa, RCBM, Lundu, Sri Aman, Simunjan.	All hospitals in Cluster Sarawak Tenggara & Sarawak Selatan.

c. Identified resident specialty or subspecialty services shall be developed on a regional basis at least one (1) cluster in each of 10 care-network zones, where there are not enough specialists or subspecialists in a particular clinical discipline.

d. The subspecialty services identified shall be provided at regional level, but may not necessarily to be provided in every region and the provision shall be determined in accordance to the needs of each region.

e. Every clinical Head of Department shall plan for the service and physical development that shall include short term and long-term plans.

f. The plans shall adhere to the current Specialty and Subspecialty Framework of the MOH Hospitals under the 12th Malaysia Plans based on the cluster needs and in accordance with the policies as determined by the MOH.

g. A short-term planning and development plans shall be developed yearly to address the current needs of services and possible expansion.

h. The development plans shall be based on the most current and existing planning norms and guidelines as determined by the MOH.[2]

1 *Surat Pekeliling Ketua Pengarah Kesihatan, Bilangan 5, Tahun 2025 – Struktur Organisasi dan Tadbir Urus Klinikal (Clinical Governance) bagi Hospital-hospital Kementerian Kesihatan Malaysia, bertarikh 21 Januari 2025.*

2 *Ceraian Minit – Mesyuarat dan Sesi Libat Urus Pengenalan Submodul "Service Expansion" dalam Fasiliti 360 (F360) MPIS Bersama Pegawai Incharge Perkhidmatan Kepakaran/Subkepakaran Hospital KKM, bertarikh 27 November 2023.*

APPENDICES
LIST OF ABBREVIATIONS
REFERENCES

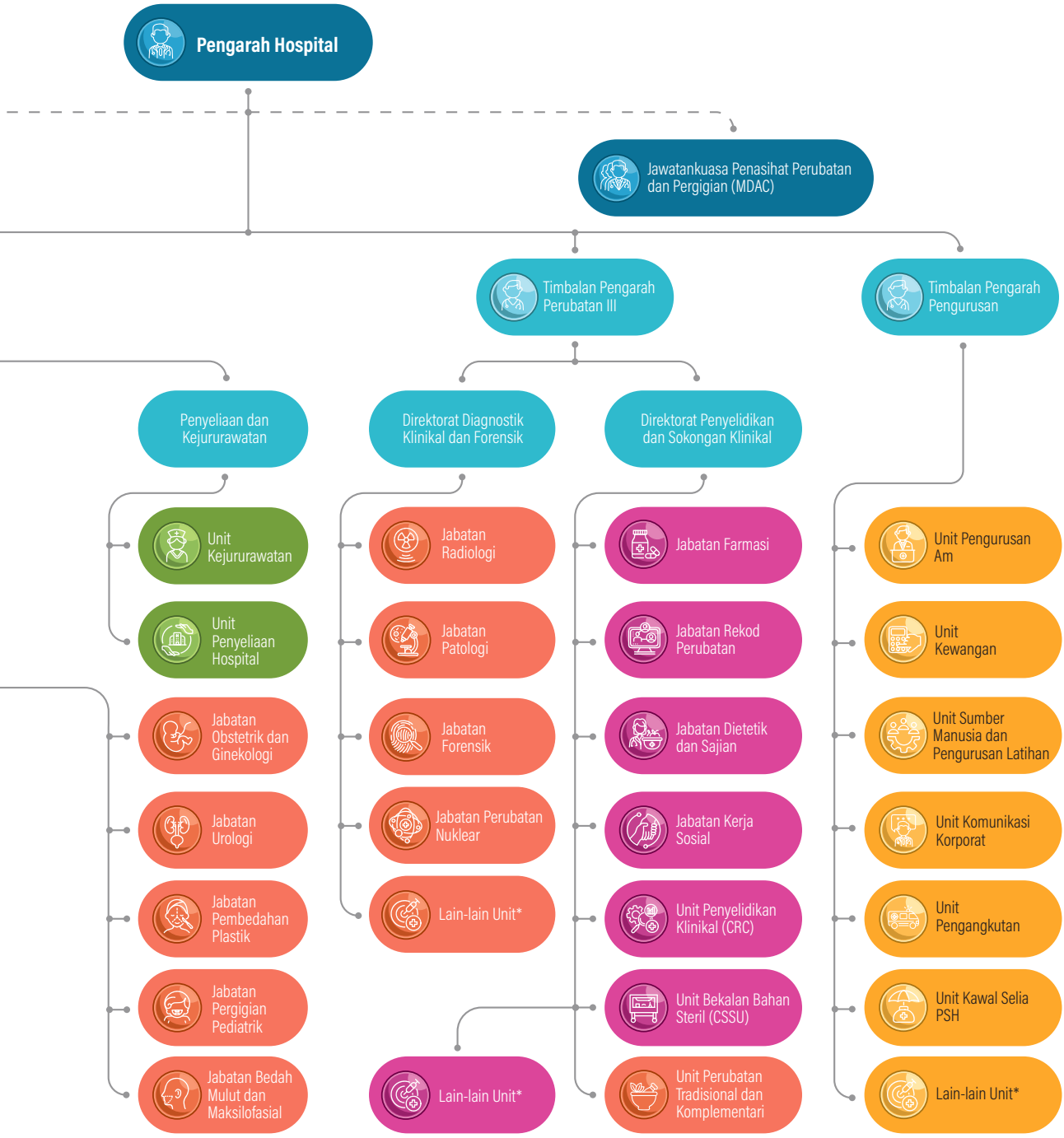

HOSPITAL BENTONG

Appendix 1

HOSPITAL OR INSTITUTION ORGANISATIONAL CHART

Hospital Type 1

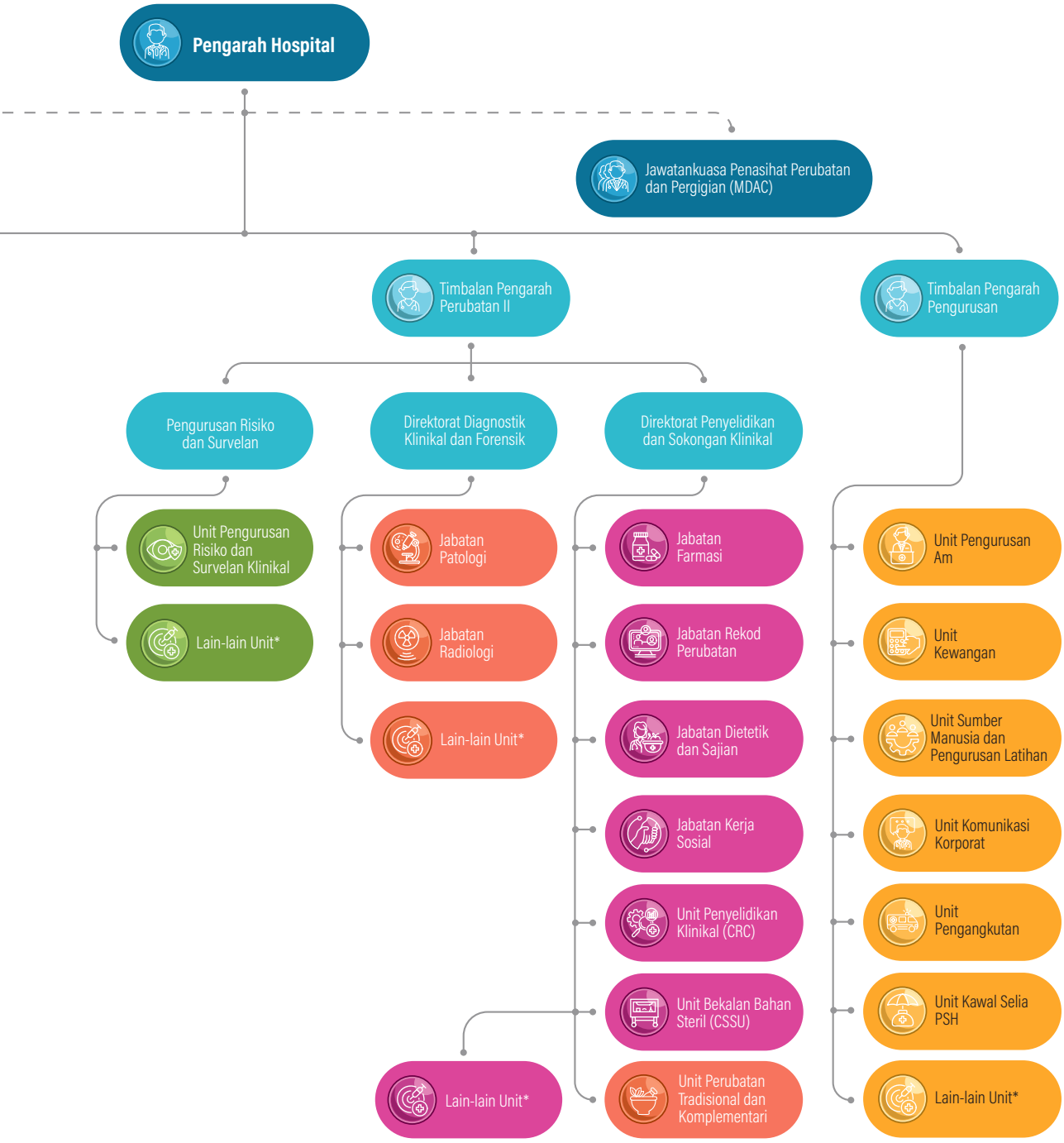
General Hospital Operational Policy 2025



Appendix 2

HOSPITAL OR INSTITUTION ORGANISATIONAL CHART

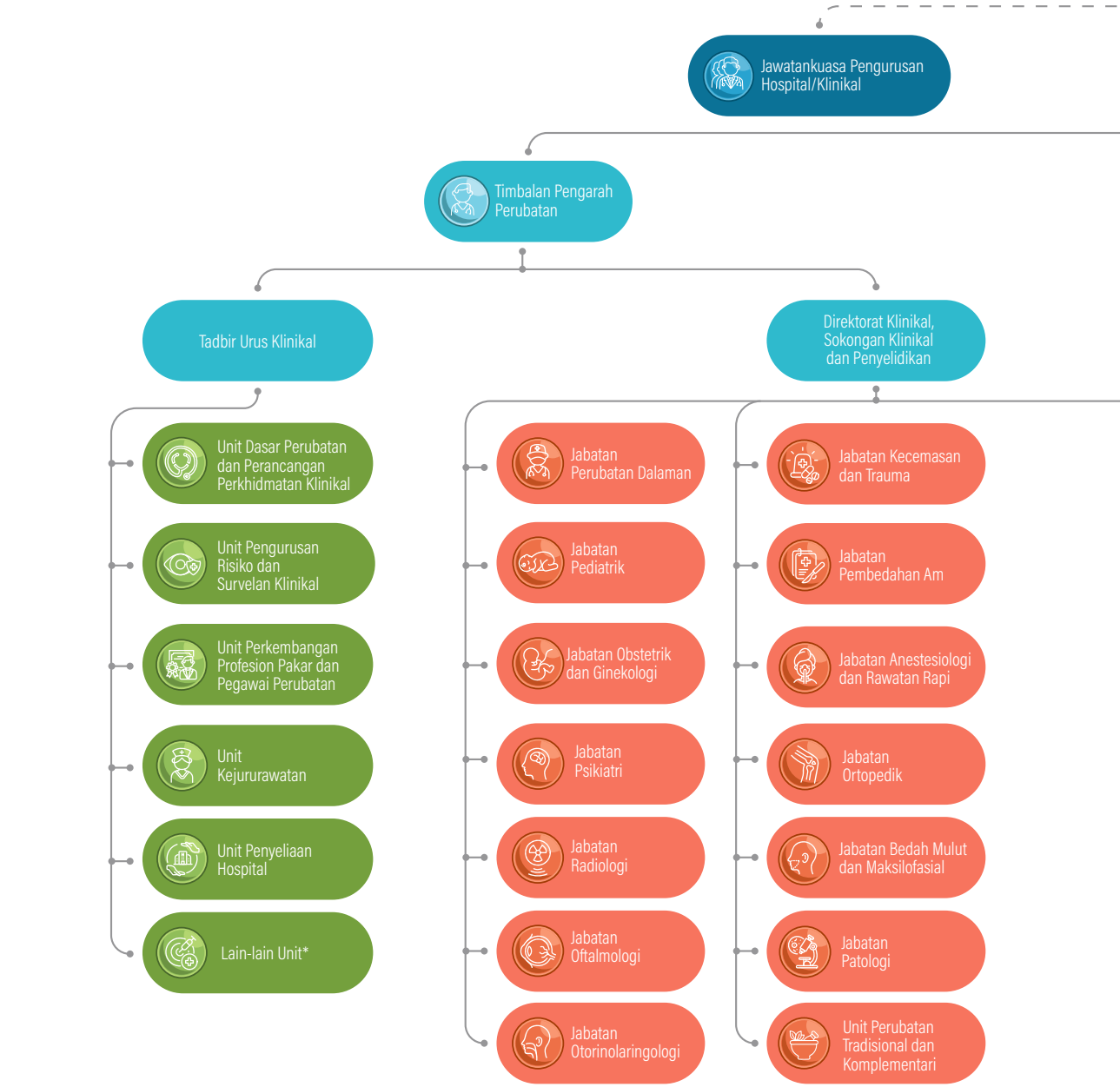
Hospital Type 2

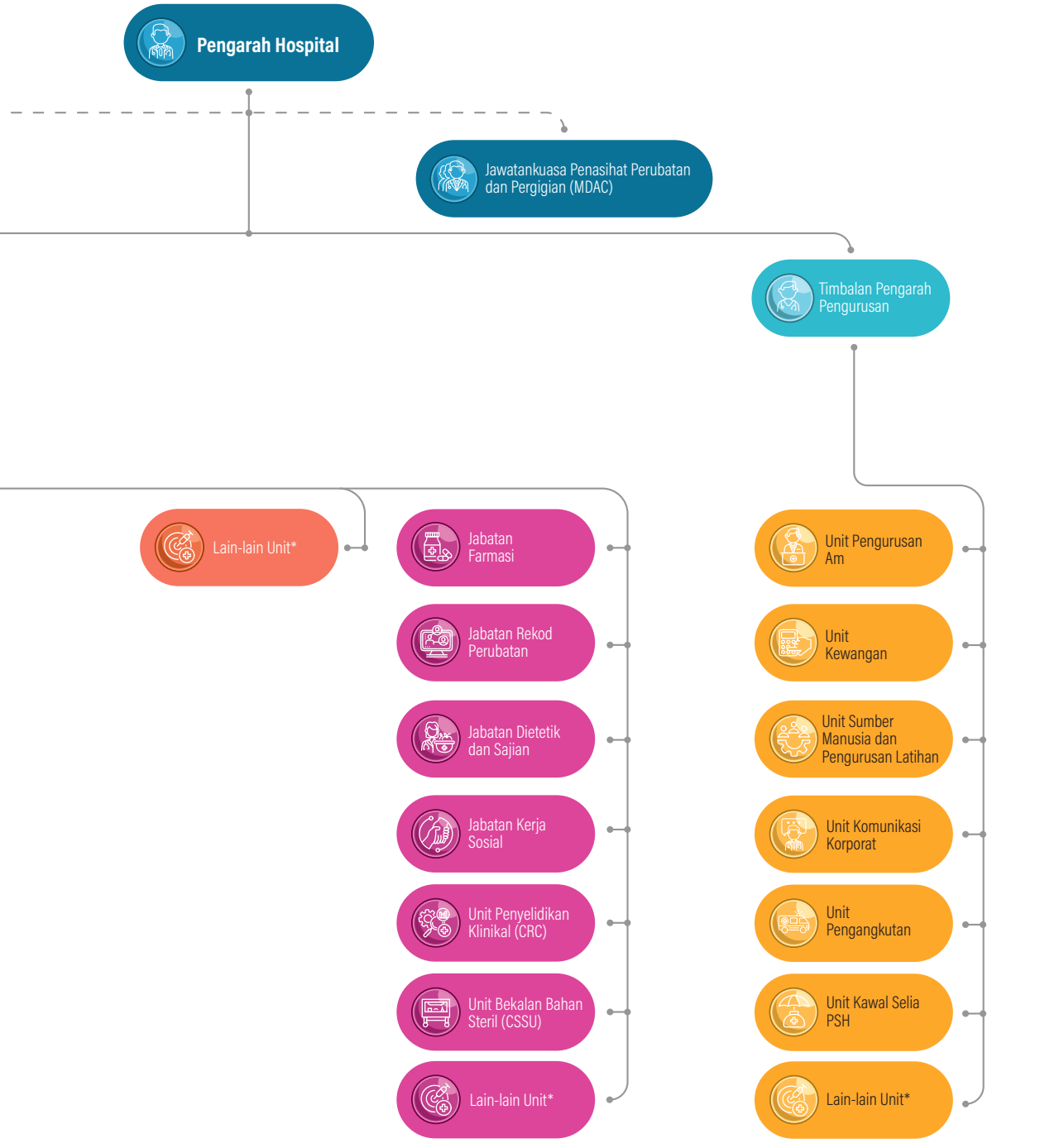

Pengarah Hospital
Jawatankuasa Penasihat Perubatan dan Pergigian (MDAC)
Timbalan Pengarah Perubatan II
Timbalan Pengarah Pengurusan
Pengurusan Risiko dan Survelan
Direktorat Diagnostik Klinikal dan Forensik
Direktorat Penyelidikan dan Sokongan Klinikal
Unit Pengurusan Risiko dan Survelan Klinikal
Lain-lain Unit*
Jabatan Patologi
Jabatan Radiologi
Lain-lain Unit*
Jabatan Farmasi
Jabatan Rekod Perubatan
Jabatan Dietetik dan Sajian
Jabatan Kerja Sosial
Unit Penyelidikan Klinikal (CRC)
Unit Bekalan Bahan Steril (CSSU)
Unit Perubatan Tradisional dan Komplementari
Lain-lain Unit*
Unit Pengurusan Am
Unit Kewangan
Unit Sumber Manusia dan Pengurusan Latihan
Unit Komunikasi Korporat
Unit Pengangkutan
Unit Kawal Selia PSH
Lain-lain Unit*
PETUNJUK
Tadbir Urus Klinikal
Perkhidmatan Klinikal
Perkhidmatan Sokongan Klinikal
Pengurusan

Appendix 3

HOSPITAL OR INSTITUTION ORGANISATIONAL CHART

Hospital Type 3

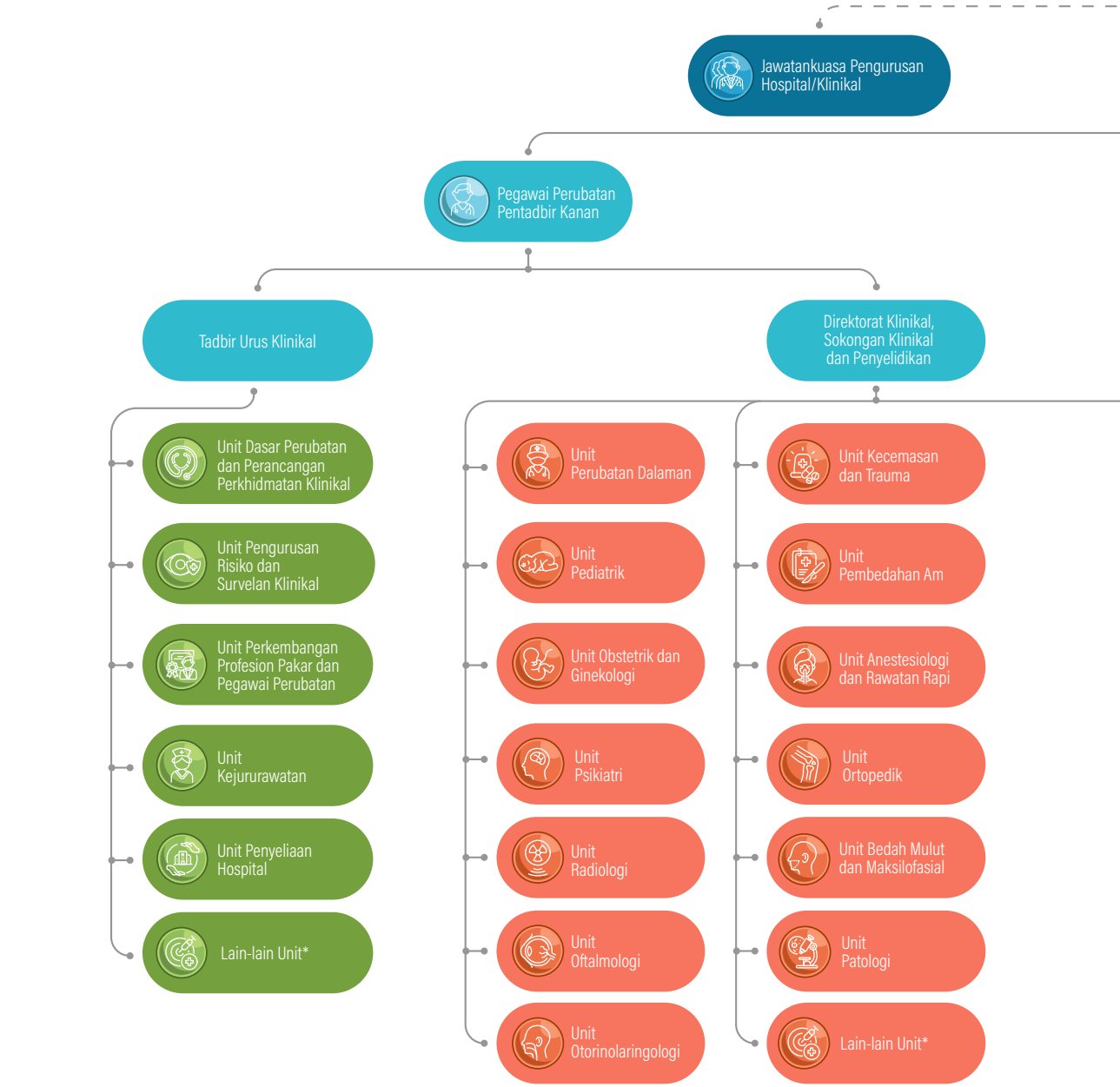


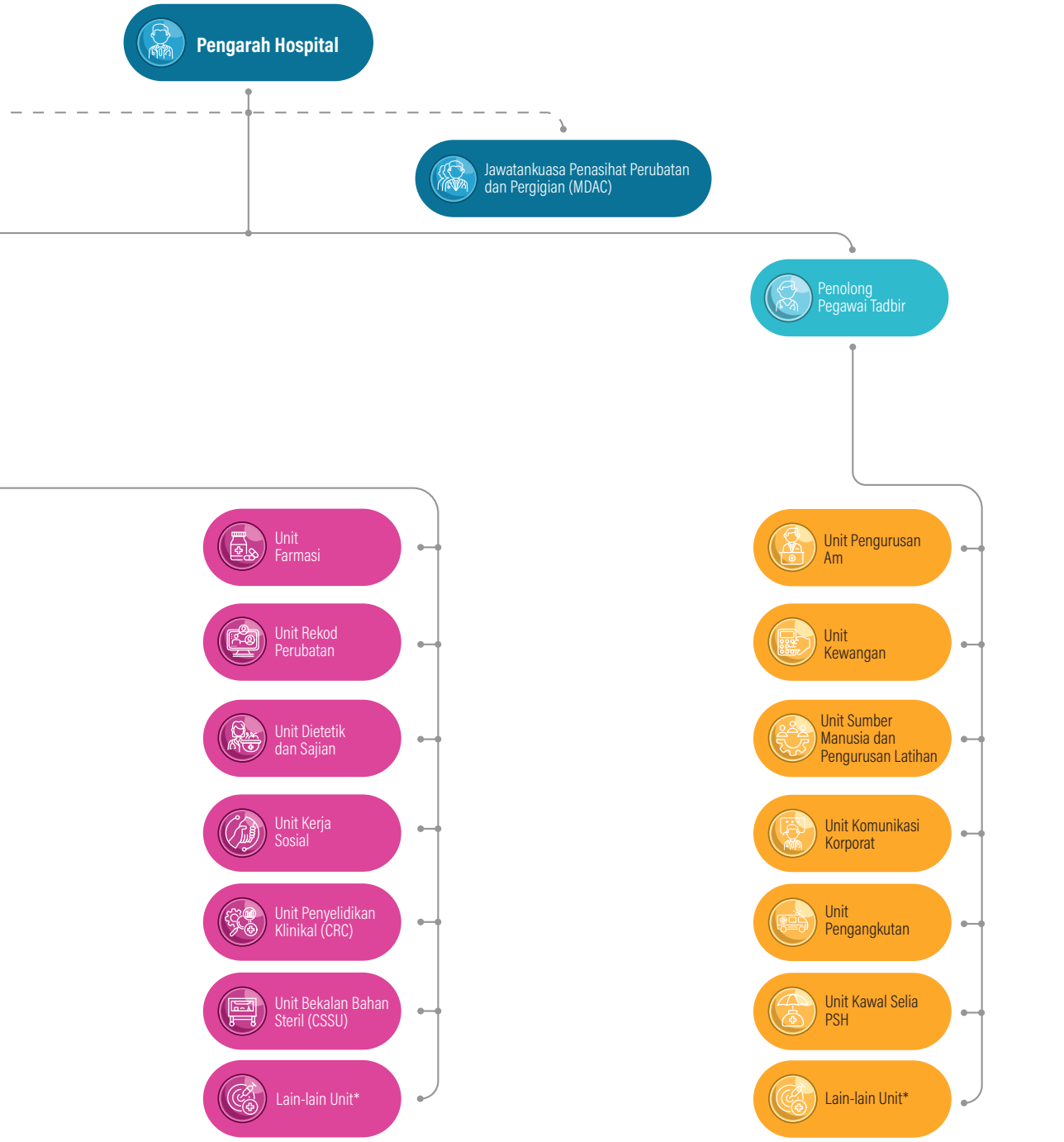

Pengarah Hospital
Jawatankuasa Penasihat Perubatan dan Pergigian (MDAC)
Timbalan Pengarah Pengurusan
Lain-lain Unit*
Jabatan Farmasi
Jabatan Rekod Perubatan
Jabatan Dietetik dan Sajian
Jabatan Kerja Sosial
Unit Penyelidikan Klinikal (CRC)
Unit Bekalan Bahan Steril (CSSU)
Lain-lain Unit*
Unit Pengurusan Am
Unit Kewangan
Unit Sumber Manusia dan Pengurusan Latihan
Unit Komunikasi Korporat
Unit Pengangkutan
Unit Kawal Selia PSH
Lain-lain Unit*
PETUNJUK
Tadbir Urus Klinikal
Perkhidmatan Klinikal
Perkhidmatan Sokongan Klinikal
Pengurusan

Appendix 4

HOSPITAL OR INSTITUTION ORGANISATIONAL CHART

Hospital Type 4




Pengarah Hospital
Jawatankuasa Penasihat Perubatan dan Pergigian (MDAC)
Penolong Pegawai Tadbir
Unit Farmasi
Unit Rekod Perubatan
Unit Dietetik dan Sajian
Unit Kerja Sosial
Unit Penyelidikan Klinikal (CRC)
Unit Bekalan Bahan Steril (CSSU)
Lain-lain Unit*
Unit Pengurusan Am
Unit Kewangan
Unit Sumber Manusia dan Pengurusan Latihan
Unit Komunikasi Korporat
Unit Pengangkutan
Unit Kawal Selia PSH
Lain-lain Unit*
PETUNJUK
Tadbir Urus Klinikal
Perkhidmatan Klinikal
Perkhidmatan Sokongan Klinikal
Pengurusan

Appendix 5

EXAMPLES OF COMMITTEES CHAIRED BY THE HOSPITAL OR INSTITUTION DIRECTOR

No.	Committee	Examples
1.	Clinical/ Technical Committee	1. Medical Advisory Committee Meeting 2. Clinical Department Head Meeting 3. Medicines Committee Meeting 4. Operation Theatre Committee Meeting 5. Infection Control Committee Meeting 6. Antibiotic Policy Meeting 7. Outbreak Coordination Meeting (SARS, Cholera, Dengue, H1N1) 8. Maternal Mortality Meeting 9. Perinatal Mortality Review Meeting 10. Perioperative Mortality Review Meeting 11. Credentialing and Privileging Committee Meeting 12. Clinical Research Committee Meeting 13. Blood and Transfusion Service Committee Meeting 14. House Officer Training Evaluation Meeting
2.	Hospital Management Committee	1. Head of Department Meeting 2. Hospital Management/Action Meeting 3. Finance and Account Management Committee Meeting 4. Management Integrity Committee Meeting 5. Visiting Board Members' Meeting (as Advisors) 6. Council Meeting with Departments 7. Occupational Health and Safety Committee Meeting 8. Medical Device Specifications Committee Meeting 9. Asset Management and Disposal Committee Meeting 10. Support Services Committee Meeting 11. Hospital Support Services Privatisation Coordination Committee Meeting 12. Development Committee Meeting 13. Complaint Investigation Meeting 14. Disaster Action Plan Meeting

No.	Committee	Examples
3.	Rules and Regulations Committee	1. SOCSO Board Meeting 2. Medical Record Management Meeting 3. Medical Board Meeting
4.	Quality Initiatives Committee	1. Quality and Productivity Steering Committee Meeting 2. Quality Improvement and Assurance Programme Committee Meeting 3. ISO 9000 Committee Meeting 4. Accreditation Committee Meeting 5. Training Committee Meeting 6. Medical Ethics Committee Meeting 7. Health Education Committee Meeting 8. Healthy Lifestyle Campaign Committee Meeting
5.	Others	Charity and Sports Meetings

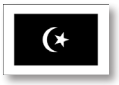
Appendix 6

LIST OF HOSPITALS/INSTITUTIONS BY CLUSTER

No.	State	Cluster	Hospital
1.	Perlis 	(Stand Alone)	**Hospital Tuanku Fauziah**
2.	Kedah 	Kedah Utara	**Hospital Sultanah Bahiyah, Alor Setar (Lead)** Hospital Jitra Hospital Kuala Nerang Hospital Pendang
		Kedah Tengah	**Hospital Sultan Abdul Halim, Sg Petani (Lead)** Hospital Yan Hospital Sik
		Kedah Selatan	**Hospital Kulim (Lead H)** Hospital Baling
		(Stand Alone)	**Hospital Sultanah Maliha, Langkawi**
3.	Pulau Pinang 	Pulau	**Hospital Pulau Pinang (Lead)** Hospital Balik Pulau
		Seberang Perai	**Hospital Seberang Jaya (Lead)** Hospital Bukit Mertajam Hospital Kepala Batas Hospital Sungai Bakap
4.	Perak 	Ipoh	**Hospital Raja Permaisuri Bainun, Ipoh (Lead)** Hospital Batu Gajah Hospital Kampar Hospital Sungai Siput Hospital Bahagia Ulu Kinta
		Perak Utara	**Hospital Taiping (Lead)** Hospital Kuala Kangsar Hospital Gerik Hospital Parit Buntar Hospital Selama
		Perak Selatan	**Hospital Teluk Intan (Lead)** Hospital Slim River Hospital Tapah
		Manjung	**Hospital Seri Manjung (Lead)** Hospital Seri Iskandar

No.	State	Cluster	Hospital
5.	Lembah Klang (WP Kuala Lumpur, Putrajaya & Selangor)   	Klang Valley 1	**Hospital Selayang (Lead)** Hospital Kuala Kubu Baru Hospital Tanjong Karang Hospital Sungai Buloh Pusat Kawalan Kusta Negara Hospital Tengku Ampuan Jemaah, Sabak Bernam
		Klang Valley 2	**Hospital Kuala Lumpur (Lead)** Hospital Orang Asli,Gombak Hospital Tunku Azizah, HWKKKL Insitut Perubatan Respiratori Hospital Rehabilitasi Cheras Hospital Ampang
		Klang Valley 3	**Hospital Tengku Ampuan Rahimah, Klang (Lead)** Hospital Kapar Hospital Shah Alam Hospital Banting
		Klang Valley 4	**Hospital Sultan Idris Shah, Serdang (Lead)** Hospital Cyberjaya Institut Kanser Negara Hospital Putrajaya Hospital Tengku Permaisuri Norashikin, Kajang
6.	WP Labuan 	(Stand Alone)	**Hospital Labuan**
7.	Negeri Sembilan 	Negeri Sembilan 2	**Hospital Tuanku Ja'afar, Seremban (Lead)** Hospital Port Dickson Hospital Jelebu Hospital Rembau
		HTAN	**Hospital Tuanku Ampuan Najihah, Kuala Pilah (Lead)** Hospital Tampin Hospital Jempol
8.	Melaka 	Melaka	**Hospital Melaka (Lead)** Hospital Alor Gajah Hospital Jasin

LIST OF HOSPITALS/INSTITUTIONS BY CLUSTER

No.	State	Cluster	Hospital
9.	Johor 	Johor Timur	**Hospital Sultan Ismail, Johor Bahru (Lead)** Hospital Kota Tinggi Hospital Mersing
		Johor Selatan	**Hospital Sultanah Aminah, Johor Bahru (Lead)** Hospital Pontian Hospital Temenggong Seri Maharaja Tun Ibrahim, Kulai Hospital Permai
		Johor Utara	**Hospital Pakar Sultanah Fatimah, Muar (Lead)** Hospital Segamat Hospital Tangkak
		Johor Barat	**Hospital Sultanah Nora Ismail, Batu Pahat (Lead)** Hospital Enche' Besar Hajjah Khalsom, Kluang
10.	Pahang 	Pahang Tengah	**Hospital Sultan Haji Ahmad Shah, Temerloh (Lead)** Hospital Jerantut Hospital Jengka Hospital Bentong Hospital Bera
		Pahang Timur	**Hospital Tengku Ampuan Afzan, Kuantan (Lead)** Hospital Pekan Hospital Muadzam Shah Hospital Rompin
		Pahang Barat	**Hospital Kuala Lipis (Lead)** Hospital Raub Hospital Sultanah Hajjah Kalsom, Cameron Highlands
11.	Terengganu 	Terengganu Utara	**Hospital Sultanah Nur Zahirah, Kuala Terengganu (Lead)** Hospital Hulu Terengganu Hospital Besut Hospital Setiu
		Terengganu Selatan	**Hospital Kemaman (Lead)** Hospital Dungun
12.	Kelantan 	Kelantan Utara	**Hospital Raja Perempuan Zainab II, Kota Bharu (Lead)** Hospital Pasir Mas Hospital Tumpat Hospital Tengku Anis, Pasir Puteh Hospital Bachok
		Kelantan Barat	**Hospital Tanah Merah (Lead)** Hospital Jeli
		Kelantan Selatan	**Hospital Sultan Ismail Petra, Kuala Krai (Lead)** Hospital Gua Musang Hospital Machang

No.	State	Cluster	Hospital
13.	Sabah 	Kota Kinabalu	**Hospital Queen Elizabeth (Lead)** Hospital Queen Elizabeth II Hospital Wanita & Kanak-Kanak, Likas Hospital Kota Belud Hospital Ranau Hospital Papar Hospital Tuaran Hospital Mesra Bukit Padang
		Tawau	**Hospital Tawau (Lead)** Hospital Semporna Hospital Kunak Hospital Lahad Datu
		Keningau	**Hospital Keningau (Lead)** Hospital Tambunan Hospital Tenom
		Sandakan	**Hospital Duchess of Kent, Sandakan (Lead)** Hospital Beluran Hospital Kinabatangan
		Kota Marudu	**Hospital Kota Marudu (Lead)** Hospital Pitas Hospital Kudat
		Beaufort	**Hospital Beaufort (Lead)** Hospital Sipitang Hospital Kuala Penyu
14.	Sarawak 	Sarawak Selatan	**Hospital Umum Sarawak (Lead)** Pusat Jantung Sarawak Hospital Serian Hospital Bau Hospital Rajah Charles Brooke Memorial Hospital Sentosa Hospital Simunjan Hospital Lundu
		Sarawak Tengah	**Hospital Sibu (Lead)** Hospital Kapit Hospital Kanowit Hospital Daro
		Sarawak Tenggara	**Hospital Sri Aman (Lead)** Hospital Betong
		Sarawak Timur	**Hospital Sarikei (Lead)** Hospital Saratok
		Sarawak Barat	**Hospital Bintulu (Lead)** Hospital Mukah Hospital Dalat
		Sarawak Utara	**Hospital Miri (Lead)** Hospital Marudi Hospital Limbang Hospital Lawas

List of Abbreviations

WORDS	DESCRIPTION
AIDS	Acquired Immune Deficiency Syndrome
ACC	Ambulatory Care Centre
ACE	Adjusted Casemix Expenditure
AMO	Assistant Medical Officer
AMR	Antimicrobial Resistance
AMS	Antimicrobial Stewardship
APC	Annual Practicing Certificate
BBA	Birth Before Arrival
BCMS	Business Continuity Management System
BCP	Business Continuity Plan
BDM	*Bilik Daftar Masuk*
BEMS	Biomedical Engineering Maintenance Services
BER	Beyond Economic Repair
BID	Brought In Dead
BMU	Bed Management Unit
BTX	*Borang Permohonan Bayaran Ex-Gratia Bencana Kerja Di Bawah Pekeliling Perbendaharaan Bil.7 Tahun 2001*
CA	Concession Agreement
CBRNE	Chemical, Biological, Radiological, Nuclear and Explosive
CCIS	Critical Care Information System
CCU	Coronary Care Unit
CD	Clinical Documentation
CDCIS	Communicable Disease Control Information System
CIDB	Construction Industry Development Board
CIS	Clinic Information System
CLS	Cleansing Services
CMC	Cluster Management Committee
CME	Continuing Medical Education
COE	Computerised Order Entry
COVID-19	Corona Virus Disease 2019
CPD	Continuing Professional Development
CPG	Clinical Practice Guideline
CPRC	Crisis Preparedness and Response Centre
CRC	Clinical Research Centre
CSSD	Central Sterile and Supply Department or Unit
DAMA	Discharge Against Medical Advice
DDMS	Digital Document Management System
DID	Death in Department
DRG	Diagnosis Related Group
DS	Discharge Summary
e-Referral	Electronic Referral System
ECG	Electrocardiogram
e-GL	Electronic Guarantee Letter
EKSA	*Ekosistem Kondusif Sektor Awam*
EMR	Electronic Medical Record
EMTS	Emergency Medicine and Trauma Services
EN	Encounter Number
ES	Encounter Summary
ETD	Emergency and Trauma Department

WORDS	DESCRIPTION
EQA	External Quality Assurance
FEMS	Facility Engineering Maintenance Services
FMIS	Forensic Management Information System
FMM	Facilities Maintenance Management
FMS	Facility Management Services
FPP	Full Paying Patient
FSO	Fire Safety Officer
GB	Governing Body
GCP	Good Clinical Practice
GHOP	General Hospital Operational Policy
GL	Guarantee Letter
HACCP	Hazard Analysis and Critical Control Points
HCP	Health Care Personnel/Provider
HDW	High Dependency Ward
HFM	Healthcare Facility Manager
HIACC	Hospital Infection and Antibiotic Control Committee
HIE	Health Information Exchange
HIMS	Health Information Management System
HIS	Hospital Information System
HIV	Human Immunodeficiency Virus
HKL	*Hospital Kuala Lumpur*
HMI	*Hospital Mesra Ibadah*
HO	House Officer
HOD	Head of Department
HPIA	Hospital Performance Indicator for Accountability
HRMIS	Human Resource Management Information System
HSIP	Hospital Specific Implementation Plan
HSS	Hospital Support Services
HTAN	*Hospital Tengku Ampuan Najihah*
HTJ	*Hospital Tuanku Jaafar*
HWCC	Hospital Wound Care Committee
HWMS	Healthcare Waste Management Services
ICR	Institute for Clinical Research
ICT	Information and Communication Technology
ICU	Intensive Care Unit
ID	Identification Document
IJN	*Institut Jantung Negara*
IHR	International Health Regulations
IT	Information Technology
JAKIM	*Jabatan Kemajuan Islam Malaysia*
JD	Job Description
JDN	*Jabatan Digital Negara*
KIK	*Kumpulan Inovatif dan Kreatif*
KKM	*Kementerian Kesihatan Malaysia*
KPI	Key Performance Indicator
KRPSWP	*Klinik Rawatan Pesakit Selepas Waktu Pejabat*
L4U	Locker4U
LH	Lead Hospital
LIS	Laboratory Information System

WORDS	DESCRIPTION
LLS	Linen and Laundry Services
MAC	Medical Advisory Committee
MAMPU	Malaysian Administrative Modernisation and Management Planning Unit *(Unit Pemodenan Tadbiran dan Perancangan Pengurusan Malaysia)*
MAP	Master Agreed Procedures
MBK	*Mencegah Bahaya Kebakaran*
MDA	Medical Device Authority
MDAC	Medical and Dental Advisory Committee
MDC	Malaysian Dental Council
MJM	*Memorandum Jemaah Menteri*
MMC	Malaysian Medical Council
MO	Medical Officer
MOE	Ministry of Education
MOH	Ministry of Health
MOF	Ministry of Finance
MOU	Memorandum of Understanding
MPIS	Medical Programme Information System
MREC	Medical Research and Ethic Committee
MRN	Medical Record Number
MRO	Medical Record Officer
MS ISO	Malaysian Standards based on the International Organization for Standardization (ISO)
MSQH	Malaysian Society for Quality in Health
MTPD	Maximum Tolerable Period Downtime
MyAP-AMR	Malaysian Action Plan on Antimicrobial Resistance
MyGovUC	My Government Unified Communications
MySED	Malaysian Strategic Plan on Emerging Diseases
MyPPSM	*Pekeliling Perkhidmatan Sumber Manusia*
NADOPOD	Notification of Accident, Dangerous Occurrence, Poisoning and Occupational Disease
NAR	No Active Resuscitation
NGOs	Non-Governmental Organisations
NIA	National Indicator Approach
NICU	Neonatal Intensive Care Unit
NIH	National Institute of Health
NLH	Non-Lead Hospital
NMIS	Nuclear Medicine Information System
NMRR	National Medical Research Registry
NTRC	National Transplant Resource Centre
OIS	Oncology Information System
OSCC	One Stop Crisis Centre
OSH	Occupational Safety and Health
OSHA	Occupational Safety and Health Act
OSM	Operation, Support and Maintenance
OT	Operation Theatre
OTMS	Operation Theatre Management System
PA	Public Address
PAHO	Pan American Health Organization
PATI	*Pendatang Asing Tanpa Izin*
PABX	Private Automatic Branch Exchange
PAC	Patient Assessment Centre

WORDS	DESCRIPTION
PACS	Picture Archiving and Communication System
PC	Personal Computer
PDCA	Plan, Do, Check, Act
PER DS 2015	Discharge Summary Form
PER ES 2015	Encounter Summary Form
PER PD 302	*Borang Ringkasan Discaj*
PER PD 102	*Buku Daftar Bersalin*
PER PD 103	*Bancian Harian Wad*
PER/PHOTO/2016	Photography/Multimedia Consent Form
PhIS	Pharmacy Information System
PICU	Paediatric Intensive Care Unit
PNM	Perinatal Mortality
POCT	Point of Care Testing
POG	Project Operational Guidelines
POMR	Post Operative Mortality Review
PPK	*Pembantu Perubatan Kesihatan*
PPP	*Penolong Pegawai Perubatan*
PSQ	Patient Satisfaction Questionnaire
PTBR	*Pelan Tindakan Bencana Rekod*
PWDs	Persons With Disabilities
QMS	Queue Management System
RCA	Root Cause Analysis
RCBM	Rajah Charles Brooke Memorial
RIS	Radiology Information System
RMP	Registered Medical Practitioner
SPUB	*Sistem Pendispensan Ubat Bersepadu*
SCN	Special Care Nursery
SDH	*Sekolah Dalam Hospital*
SIQ	Shortfall In Quality
SKU	*Sasaran Kerja Utama*
SMS	Short Message Service
SOP	Standard Operating Procedure
SSPA	*Sistem Saraan Perkhidmatan Awam*
TAT	Turn Around Time
TC	Teleconsultation
T&CM	Traditional & Complementary Medicine
TLK	*Tempat Letak Kenderaan*
TOP	Tissue and Organ Procurement
TPA	*Tatacara Pengurusan Aset Alih Kerajaan*
TPS	*Tatacara Pengurusan Stor Kerajaan*
UACP	User Access Control Policy
UMP	*Ubat Melalui Pos*
UNHCR	United Nation High Commissioner for Refugees
UPOH	*Unit Perolehan Organ Hospital*
VAS	Value Added Service
VCM	Validation Committee Meeting
VIP	Very Important Person
WBB	*Waktu Bekerja Berperingkat*
WHO	World Health Organization
WP	*Wilayah Persekutuan*

References

Please scan the QR code or visit the provided link below to access the relevant circulars, letters, and guidelines, which are organised by chapter.

QR CODE

LINK

https://shorturl.at/N76m7

For any questions or further information regarding this **General Hospital Operating Policy (GHOP),** please contact us at the address below:

Hospital Services Management Unit
Medical Development Division
Ministry of Health Malaysia
Level 5, Block E1, Complex E
Federal Government Administrative Centre
62590 Putrajaya, MALAYSIA
Tel: +603 8888 1139
Website: www.moh.gov.my

MEDICAL PROGRAMME
MINISTRY OF HEALTH MALAYSIA

GENERAL HOSPITAL OPERATIONAL POLICY

THIRD EDITION 2025

ISBN 978-629-95335-0-4