MINISTRY OF HEALTH
MALAYSIA

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ISBN: 978-967-0769-15-8

MINISTRY OF HEALTH MALAYSIA

GENERAL HOSPITAL OPERATIONAL POLICY IN ICT ENVIRONMENT

MEDICAL DEVELOPMENT DIVISION MINISTRY OF HEALTH MALAYSIA

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ISBN: 978-967-0769-15-8
November 2016

Hospital Management Services Unit
Medical Development Services Section
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GENERAL HOSPITAL OPERATIONAL POLICY IN ICT ENVIRONMENT GHOP_ICT

MEDICAL DEVELOPMENT DIVISION
MINISTRY OF HEALTH MALAYSIA

GENERAL HOSPITAL OPERATIONAL POLICY IN ICT ENVIRONMENT FOREWORD

The advancement of Information and Communication Technology for the past decades has transformed the way we are managing patients and administrating governance in the hospital environment. In addition, more advance and intricate technology will continue to influence our daily practice. The true fact is all healthcare providers in the hospitals should make subtle adjustments every now and then in order to keep us abreast and maintain our relevance in line with the explosion of technology during this highly competitive era.

Being a clinician and administrator myself, I believe it is timely for MOH to publish this policy book which will assist the healthcare providers at hospital level in their day to day operations, in particular those working in the hospitals equipped with Hospital Information System. There is a need for each individual hospital to adapt the policies for its own use. Minor changes may be made to suit local needs with reasons for change must be clearly justified. Bear in mind that this book is a living document of policies and changes will occur from time to time as there will be continuing breakthrough in the technology. I hope that from time to time, hospital managers will keep track of changes in policies and note them against relevant sections so that future editions may be more representative and comprehensive.

Last but not least, I would like to congratulate the Medical Development Division and the drafting committee of the GHOP_ICT for their relentless effort in taking the initiative to develop and publish this document. It is my hope that this document will serve as a reference for all healthcare providers in managing hospital during this epoch.

DATUK DR. NOOR HISHAM BIN ABDULLAH
DIRECTOR GENERAL OF HEALTH MALAYSIA

GENERAL HOSPITAL OPERATIONAL POLICY IN ICT ENVIRONMENT PREFACE

Ministry of Health Malaysia (MOH) has embarked on Health Information and Communication Technology (Health ICT) for use in government hospitals since 1999. Since then, the number of hospitals using ICT as a tool to render service has increased in numbers. Eventually all MOH hospitals shall use Government own Hospital Information System ie HIS@KKM.

All government hospitals, either manual or using HIS abide to the General Hospital Policy published in 2013. This GHOP_ICT applies to hospitals with HIS systems in place. Whenever MOH Enterprise Architecture (EA) framework is made available, all policies shall be incorporated into EA landscape.

Transformational health care delivery which focuses on Quality, Safety and Efficiency, needs an enabler, ICT, as a tool in almost every aspect, and not limited to governance, data generation, data sharing, electronic medical record keeping, service delivery for patient care, consultations among doctors and interfacility consultations and referrals. GHOP_ICT delineate standardized process, standardized data capture which are among relevant criteria for future interoperability in between systems and for data analytics.

GHOP_ICT abide to ICT Policy by MAMPU, other ICT Policies and follow the endorsed Health Informatics Standards. It is a living document that shall follow technology advancement and hospitals require adopting changes in an innovative way with regards to relevant process in their set up.

Many hours of specialists time from various hospitals and discipline, MOH personals were needed as inputs and finalization to this GHOP_ICT to make it applicable and friendly in a hospital setting. It shall also serve as a reference for future developments of any system, especially for a secondary or tertiary health care set up.

DATO' DR. HJ. AZMAN BIN HJ. ABU BAKAR
DIRECTOR OF MEDICAL DEVELOPMENT DIVISION
MINISTRY OF HEALTH, MALAYSIA

CONTENTS

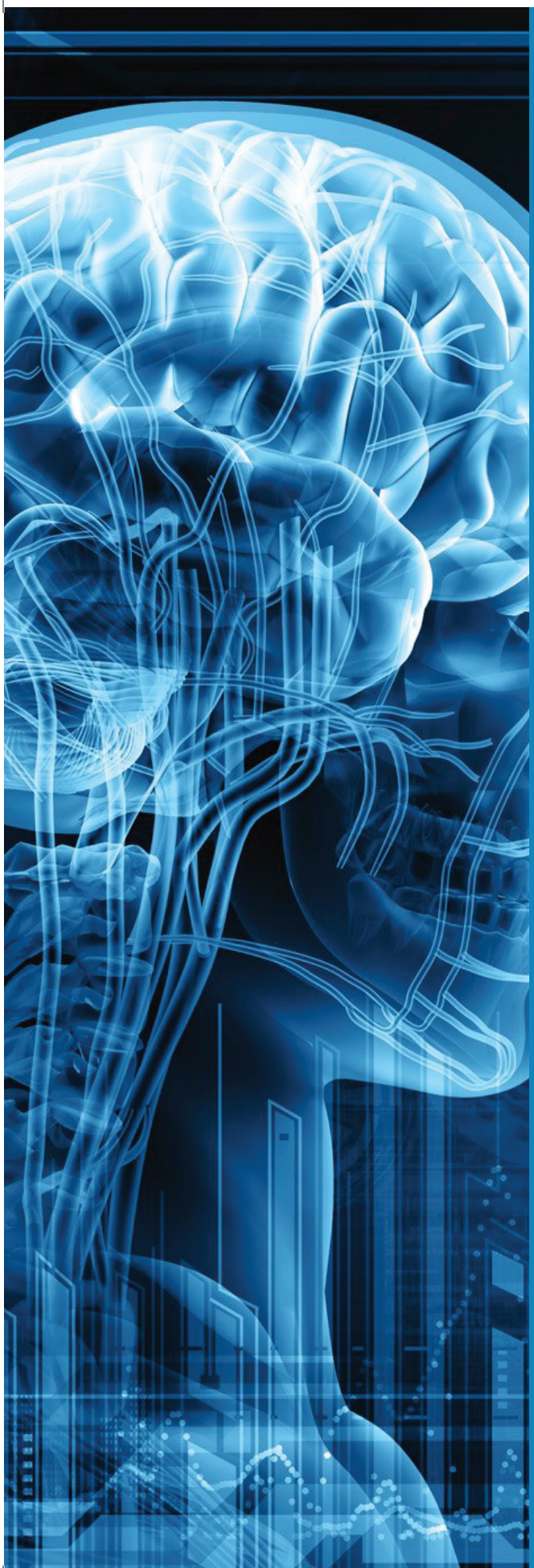
GLOSSARIES

Word	Glossary
AIDS	Acquired Immune Deficiency Syndrome
AOR	At Own Risk
BBA	Born Before Arrival
BCP	Business Continuity Plan
BDM	*Bilik Daftar Masuk*
BID	Brought In Dead
BP	*Bahagian Pembangunan*
BTX	*Borang Permohonan Bayaran Ex-Gratia Bencana Kerja Di Bawah Pekeliling Perbendaharaan Bil.7 Tahun 2001*
CA	Concession Agreement
CCIS	Critical Care Information System
CCU	Coronary Care Unit
CD	Clinical Documentation
CIS	Clinic Information System
CME	Continuous Medical Education
COE	Computerized Order Entry
CPD	Continuous Professional Development
CRC	Clinical Research Centre
CSI	Crime Scene Investigation
CSSD	Central Sterilise and Supply Department
DAMA	Discharge Against Medical Advice
DDSA	Data Dictionary *Sektor Awam*
DIL	Dangerously Ill List
DKICT	*Dasar Keselamatan* ICT
Dr.	Doctor
DS	Discharge Summary
e-Referral	Electronic Referral System
ECG	Electrocardiogram
ED	Emergency Department
eGL	Electronic Guarantee Letter
EMR	Electronic Medical Record
EN	Encounter Number
ENT	Ear, Nose and Throat
Env.	Environmental
ES	Encounter Summary
ETD	Emergency and Trauma Department
FMIS	Forensic Management Information System
FPP	Full Paying Patient
GCP	Good Clinical Practice

Word	Glossary
GHOP	General Hospital Operational Policy
GHOP_ICT	General Hospital Operational Policy in ICT environment
HACCP	Hazard Analysis and Critical Control Points
HCP	Health Care Personnel/Provider
HDW	High Dependency Ward
HIS	Hospital Information System
HIV	Human Immunodeficiency Virus
Hj.	*Haji*
Hjh.	*Hajjah*
HKL	*Hospital Kuala Lumpur*
HMIS	*Health Management Information System*
HOD	*Head of Department*
HR	*Human Resource*
HRMIS	Human Resource Management Information System (*Sistem Maklumat Pengurusan Sumber Manusia)*
HSIP	Hospital Specific Implementation Plan
IC	Identification Card
ICT	Information and Communication Technology
ICU	Intensive Care Unit
ID	Identification Document
IJN	*Institut Jantung Negara*
IKN	*Institut Kanser Negara*
IPTA	*Institut Pengajian Tinggi Awam*
IPTS	*Institut Pengajian Tinggi Swasta*
ISO	International Organization for Standardization
IT	Information Technology
ITD	Information Technology Department
JPA	*Jabatan Perkhidmatan Awam*
JPICT	*Jawatankuasa Pemandu ICT*
JPN.LM	*Jabatan Pendaftaran Negara. Lahir Mati*
KKM	*Kementerian Kesihatan Malaysia*
KMK	*Kumpulan Meningkat Mutu Kerja* (Quality Control Circle)
KPI	Key Performance Indicator
KPK	*Ketua Pengarah Kesihatan*
LIS	Laboratory Information System
MAC	Medical Advisory Committee
MAMPU	Malaysian Administrative Modernisation and Management Planning Unit *(Unit Permodenan Tadbiran dan Perancangan Pengurusan Malaysia)*
MAP	Master Agreed Procedures
MMC	Malaysian Medical Council

Word	Glossary
MO	Medical Officer
MOH	Ministry of Health
MOU	Memorandum of Understanding
MREC	Medical Research and Ethic Committee
MRN	Medical Record Number
MRO	Medical Record Officer
MyDRG	Malaysian Diagnosis Related Grouping
MyHix	Malaysia Health Information Exchange
NADOPOD	Notification Of Accident, Dangerous Occurrence, Occupational Poisoning and Occupational Disease *(Notifikasi Penyakit Pekerjaan & Keracunan Pekerjaan Di Bawah Peraturan Keselamatan & Kesihatan Pekerjaan)*
NHS	National Health Service
NIA	National Indicator Approach
NIH	National Institute of Health
NMRR	National Medical Research Registry
OSHA	Occupational Safety and Health Act
OSM	Operation, Support and Maintenance
OT	Operation Theatre
OTMS	Operation Theatre Information System
P.P	*Pekeliling Perkhidmatan*
PA	Public Address
PABX	Private Automatic Branch Exchange
PAC	Patient Assessment Center
PER-PD 102	*Buku Daftar Bersalin*
PER-PD 103	*Bancian Harian Wad*
PhIS	Pharmacy Information System
Pin.	*Pindaan*
PKPA	*Pekeliling Kemajuan Pentadbiran Awam*
PNM	Perinatal Mortality
QMS	Queue Management System
RIS	Radiology Information System
SBPU	*Sistem Bersepadu Pemberian Ubat*
SIQ	Shortfall In Quality
SMS	Short Message Service
SOP	Standard Operating Procedure
SPKPK	*Surat Pekeliling Ketua Pengarah Kesihatan*
SPP	*Sistem Pengurusan Pesakit*
TAT	Turn Around Time
TC	Teleconsultation
TCM	Traditional and Complimentary Medicine

Word	Glossary
TRPI	Technical Requirement and Performance Indicators
UACP	User Access Control Policy
UiTM	*Universiti Teknologi Mara*
UNHCR	United Nation High Commissioner for Refugees
VIP	Very Important Person
VVIP	Very Very Important Person



PREAMBLE

MOH VISION & MISSION

1. PREAMBLE

General Hospital Operational Policy In ICT Environment (GHOP_ICT): General statement of intent and direction in order to meet the operational functions of IT[1] hospitals.

Purpose: The purpose of this document is primarily to assist and facilitate hospital management team to effectively manage the Ministry of Health (MOH) hospitals using ICT as a tool to render service. GHOP_ICT serves as a reference and may be adapted to local needs. To achieve the objectives of the hospital, the policies cut across the whole organization with a scope that shall cover 4 main components of the hospital i.e. people, technology, work process and structure.

2. MOH VISION & MISSION

2.1 Vision

A nation working together for better health.

2.2 Mission

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

i. to facilitate and support the people to:
   a. attain fully their potential in health
   b. appreciate health as a valuable asset
   c. take individual responsibility and positive action for their health

ii. to ensure a high quality health system that is:
   a. customer centered
   b. equitable
   c. affordable
   d. efficient
   e. technologically appropriate
   f. environmentally adaptable
   g. innovative

[1] *IT : Information Technology pertaining to hospitals using systems as enabler eg Hospital Information System (HIS), Sistem Pengurusan Pesakit (SPP) etc.*

iii. with emphasis on:

a. quality

b. innovation

c. health

d. promotion

e. respect for human dignity

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

2.3 Hospital Vision & Mission

Vision – Hospital vision (if available) shall be in line with MOH

Mission – Hospital mission (if available) shall be dynamic and reviewed regularly


ORGANIZATION

3. ORGANIZATION

3.1 Hospital Organization Chart - Organizational Chart of individual hospital

Refer to **Appendix 1 - 4**

3.2 Organizational Aspects

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

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

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

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

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

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

3.3 Hospital Overview – Individual hospital

- Background
- Facilities available
- Services provided
- Manpower
- Challenges and Achievement
- Way forward

3.4 Committees

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

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

iii. Clinical matters shall be discussed at the MAC, whose members are representatives from the various clinical directorates and chaired by the specialists. MAC shall function as a 'clinical advisor' to the management committee with regards to clinical governance.

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

v. In IT hospitals, ICT Committee shall look into matters regarding ICT planning, implementation, monitoring and maintenance. The ICT Committee shall comprise of Hospital Champions led by Hospital Director, Clinical Champions led by Clinicians, Super-users and IT Department acting as the Secretariat.

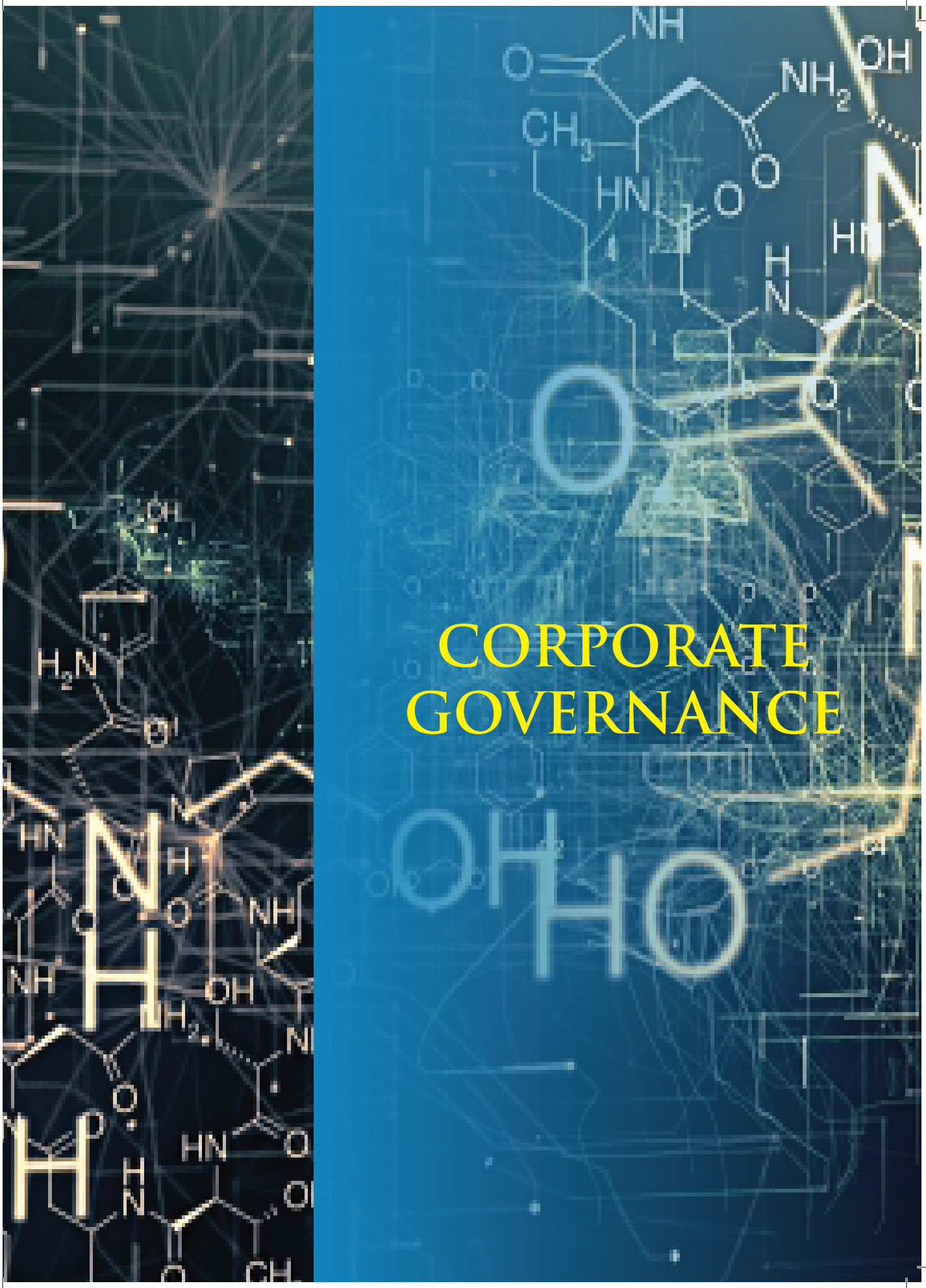
vi. Refer to: SPKPK Bil.7/2000 Garis Panduan Struktur Organisasi Pengurusan Hospital dated 22 December 2000.

3.5 Hospital Clusters

In the intention of increasing hospital efficiency services, hospitals shall be clustered accordingly in various states. Hospital cluster policy shall later be incorporated.

3.6 Lean Healthcare Initiatives in MOH hospitals

The adoption of Lean Healthcare Initiatives in service delivery shall embrace ICT.



CORPORATE GOVERNANCE

4. CORPORATE GOVERNANCE

Definition and Purpose of Corporate Governance

Corporate governance is a term that refers broadly to the rules, processes, or laws by which hospital services are operated, regulated, and controlled. The term can refer to internal factors defined by the officers, owners or constitution of an organization, as well as to external forces such as consumer groups, clients and government regulations. It provides a structure that for the benefits of everyone in the organization, by ensuring that the organization adheres to accepted ethical standards, best practices as well as to formal laws.

4.1 General Administration

4.1.1 Letters and Documents

i. The General Administration Unit shall be responsible for the management of all incoming and outgoing official letters, faxes[2] and e-mail communication[3].

ii. The hospital shall have a common and systematic hospital filing system of all official documents. Both incoming and outgoing letters shall be filed accordingly.

iii. Incoming letters/documents shall be registered, minutes recorded and dispatched to the respective department/unit within specified time. Urgent letters shall be dispatched immediately and the respective department/unit informed by phone.

iv. All outgoing official letters shall use the standard letterhead of the hospital[4].

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

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

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

4.1.2 Office Equipment and Supplies

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

[2] *Pekeliling Perkhidmatan (PP) Bil. 5/2007- Pengurusan Pejabat*
[3] *Surat Pekeliling Am Ketua Setiausaha KKM Bil. 2/2013 – Dasar Keselamatan ICT KKM Versi 4.0*
[4] *Surat Pekeliling Perbendaharaan Bil.5 Tahun 2007: Tatacara Pengurusan Aset Alih Kerajaan*

ii. The department/unit head shall be responsible for maintaining the asset and inventory list and to ensure proper use of equipment and supplies.

iii. Certain office equipment shall be shared among several departments/units. Shared equipment shall be under the responsibility of the department/unit where the equipment is/are located.

iv. The hospital's Asset Management Unit/Committee shall be responsible for the following functions i.e. receiving, registering, usage, safekeeping, inspection, maintenance and disposal.[5]

4.1.3 Meeting Room Facilities

i. The use of meeting rooms and other facilities like auditorium, seminar rooms etc. shall be coordinated. A designated person or Unit shall be responsible for coordinating these services.

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

4.2 Finance

4.2.1 Budget Allocation and Expenditure

i. Hospital fund shall be allocated according to Activity.

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

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

iv. A Finance Committee shall be established to discuss financial and account issues including expenditure status, budget reallocation and additional requirement. The hospital director shall be fully responsible for the management of allocation and expenditure of the hospital.

4.2.2 Procurement

i. Procurement of hospital supplies or specific items shall be coordinated by the relevant department.[6]

[5] *Pekeliling Kemajuan Pentadbiran Awam, Bil 2/1991 Arahan Perkhidmatan Bab 1-Bab 8*
[6] *Arahan Perbendaharaan Bab A-Bab C*

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

iii. All procurement related to ICT need approval from MOH and other relevant agencies.[7]

4.2.3 Claims and loans

i. Staff shall be required to submit claims within the first ten days of the following month. It shall be completed, signed and attached with the necessary documents.

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

iii. Government loan application shall be submitted based on eligibility and attached with the necessary forms and document.[8]

iv. Refer to *Elaun dan Kemudahan Perkhidmatan Awam, Bahagian Saraan JPA 2012 at jpa.gov.my*

4.3 Revenue Collection (Hospital revenue)

4.3.1 Hospital Charges

i. Fees shall be charged in accordance to the Fee Order (Medical) 1982, Fee Order (Medical) (Amendment) (Foreigner) 2003, Fee Order (Medical) (Full Paying Patient) 2007, Fee Order (Medical) (Cost of Service) 2014 and the MOH Finance circulars. Procedures not listed in the Fee Order shall be forwarded to the Finance Division of MOH for approval of fee. The hospital shall make available the information on hospitals fees / charges to all parties.

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

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

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

v. Refer to

[7] *Surat Pekeliling Am KKM Bil.1/2016 – Tatacara Pelaksanaan Projek ICT di KKM*
[8] *Elaun dan Kemudahan Perkhidmatan Awam, Bahagian Saraan JPA 2012 at jpa.gov.my*

- Fee Order (Medical) 1982, (*Jadual A Caj Pesakit Luar, Pengecualian*) and
- *Akta Acara Kewangan*,
- *Surat Pekeliling Bahagian Kewangan Bilangan 2 Tahun 2012 Pelaksanaan Pengecualian Caj Pendaftaran Jabatan Pesakit Luar Pakar sebanyak RM5.00 dan Pengurangan Caj sebanyak 50% bagi Pesakit Kelas 3 di Hospital/Klinik Kementerian Kesihatan Malaysia kepada Semua Pesakit Warganegara yang Berumur 60 tahun dan Ke atas*, and
- *Surat Pekeliling Bahagian Kewangan Bil.1/2014 – Garispanduan Pelaksanaan Perintah Fi (Perubatan)(Kos Perkhidmatan) 2014.*

4.3.2 Billing & Payment

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

ii. For HIS hospital interim bill can be generated upon request. The system has the function to automate flow of any chargeable event to the future billing.

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

iv. The hospital shall receive payment in cash, money order, postal order, bank draft, bankers' cheques, online banking or credit/debit card. Personal cheques are not accepted. Receipts shall be issued upon payment.

v. Revenue collection shall be carried out by authorized personnel at a designated revenue counter.

4.4 Human resource

4.4.1 Human Resource Planning

i. The hospital management shall ensure there are systems to provide appropriate numbers of people with required skills are made available in the hospital. The hospital management is responsible for human resource training in accordance to service needs and expansion plan.

4.4.1.1 Orientation

i. Newly appointed Staff shall be informed about the terms and conditions of appointment as in the General Order and PKPA (*Perintah-Perintah Am*) *Peraturan-peraturan Pegawai Awam (Perlantikan, Kenaikan Pangkat dan Penamatan Perkhidmatan)*

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

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

iv. Hands-on training on ICT skills shall be arranged for staff in the IT hospitals.

4.4.1.2 Placement

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

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

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

iv. Hospital director is to ensure placement of sufficient IT officers for efficient running of an IT hospital.

v. Refer to:

- *SPKPK Bil.4/2005 Penempatan Secara Bergiliran (Rotational Posting) bagi Pegawai Perubatan di Hospital dan Klinik Kesihatan Malaysia* dated 20 July 2005,
- *SPKPK Bil.4/2010 Garispanduan Bertugas atas Panggilan Untuk Pegawai Perubatan dan Pegawai Perubatan Siswazah di Hospital-hospital KKM* dated 12 March 2010 and
- *Buku Panduan Program Pegawai Perubatan Siswazah, Edisi 2012, KKM*

4.4.1.3 Work Attendance and Leave

i. Staff shall record their daily attendance and movements within working hours using the appropriate person attendance system e.g. punch card, record book, access card, special forms etc. Staff requesting for time-off during office hours shall complete the form *(Kebenaran Untuk Meninggalkan Pejabat Dalam Waktu Bekerja* [9]).

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

iii. Staff shall submit leave form in advance before taking leave. They shall make sure the leave has been approved before taking the leave. Use of HRMIS for leave application is encouraged.

iv. Staff shall inform their department/unit head if they are not well to be present at work and/or has been given Sick Certificates.

v. Staff participating in Medical And Humanitarian Aid Mission shall be accorded a maximum of 21 day non-recorded leave (including weekends and holidays), when the mission is organized by a recognized body[10].

4.4.2 Professional Development

vi. The hospital management shall facilitate Continuous Medical Education (CME) and Continuous Professional Development (CPD) activities in the hospital.[11]

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

iii. Staff shall be required to attend CME/CPD/training programme sessions for at least 7 days in a year. Where applicable, log book or online CPD should be updated

4.4.2.1 Performance Evaluation

i. Every staff shall have a *Fail Meja* which contain the job description, responsibilities and related work guidelines and procedures.

ii. Staff in consultation with respective Heads of Department

[9] *Perintah Am 5 Bab G: Borang Permohonan Kebenaran Meninggalkan Pejabat Dalam Waktu Bekerja*
[10] *Perintah Am 42(a) Bab C*
[11] *SPKPK Bil.4/2007 Pelaksanaan Pembelajaran Profesional Berterusan "Continuing Professional Development (CPD)" dated 11 July 2007*

shall prepare the Annual Work Targets *(Sasaran Kerja Tahunan)* and indicators e.g. Key Performance Indicators for measuring achievement at the beginning of the year.

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

iv. Performance evaluation shall be carried out 6 monthly and annually and at appropriate intervals using the standard format in a just and fair manner.

4.4.3 Ethics & Discipline

4.4.3.1 Dress Code & Work Behaviour

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

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

iii. Staff shall wear their respective uniform or proper working attire when they are at work. Batik shall be worn on Thursdays.

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

v. Refer to:

- *Perintah-Perintah Am*,
- *SPKPK Bil.1/2000 Amalan Etika Profesion Perubatan Yang Baik* dated 26 May 2000,
- *SPKPK Bil.4/1989 Kod Pakaian Untuk Doktor* dated 26 October 1989, and
- *SPKPK Bil.3/1987 Penyeliaan Doktor-doktor Di Jabatan Klinikal* dated 6 April 1987)

4.4.3.2 Disciplinary Problem

i. Monitoring of staff performance shall be continuous. Staff with disciplinary problems shall be given counseling before being referred for disciplinary action. For disciplinary actions, please refer to General Orders[12].

[12] *Perintah Am Bab D Tatatertib*

4.4.4 Staff Welfare & Safety

4.4.4.1 Staff Welfare

i. The hospital shall establish clubs or associations e.g. *Kelab Sukan dan Kebajikan*, and Puspanita to provide opportunity for staff to get together, participate in sports or carry out other recreational activities and staff welfare.

ii. Hospitals are encouraged to establish Wellness Clinic or health clinic for staff.

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

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

iv. An officer or his beneficiaries must complete Part 'A' i.e. BTX form. This form can be obtained through the Treasury website (www.treasury.gov.my)[13]. Completed forms should be submitted to the Head of Department. The Head of Department shall investigate and prepare a report on the disaster and complete Part 'B' of the application form. The form need to be submitted along with required documents to the State Health Department and Ministry.

4.4.4.2 Safety

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

ii. Occupational Safety and Health Act (OSHA) Committee must be established in hospitals to facilitate safety regulations and minimize risk to patients, staff, visitors and contractors. Refer to OSHA guideline for details.

[13] *Guidelines for Ex-Gratia Payment Scheme for Public Servants under Treasury Circular No. 7 of 2001*

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

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

v. Occupational and infectious diseases shall be notified accordingly.[14]

4.5 Hospital Safety and Security

4.5.1 Hospital Safety

4.5.1.1 Disaster Preparedness

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

ii. The hospital shall develop disaster preparedness plans and policies for events such as fire, flood, tremors, earthquake, bomb threats, chemical threats, biological threat, mass casualty and others.[15]

iii. Disaster preparedness plans[16] [17] shall be communicated to all staff including Business Continuity Plan (BCP) for HIS.

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

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

4.5.1.2 Fire Safety

i. The Hospital shall appoint a fire safety officer and prepare a fire contingency plan

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

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

[14] SPKPK Bil.9/2010 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

[15] SPKPK Bil. 12/2001 Pelan Tindakan Bencana Untuk Hospital-hospital di Bawah KKM dated 4 December 2001

[16] Panduan Penyediaan Pelan Tindakan Bencana Rekod (PTBR) Kerajaan 2012;

[17] Dasar Keselamatan ICT MAMPU 2010 Versi 5.3

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

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

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

4.5.1.3 Radiation Protection

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

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

iii. Staff exposed to radiation shall have their blood count checked regularly and undergo necessary medical examination.

iv. Refer to:

- *SPKPK Bil.10/2002 Panduan Tatacara Pengendalian Filem X-Ray Di Hospital- hospital dan Klinik Kesihatan Malaysia* dated 14 October 2002,
- SPKPK Bil.9/1994 Guidelines And Action Plan On Management Of Radiation Emergencies dated 28 November 1994,
- *SPKPK Bil.10/1987 Penggunaan Mesin X-Ray MMR di Hospital-hospital dated 6 October 1987,(iv) SPKPK Bil.6/1986 Menghadkan Penggunaan Mesin X-Ray Jenis Mobile/ Portable untuk Kegunaan Radiologi di Wad-wad* dated 25 March 1986.

4.5.1.4 Infection Control

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

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

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

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

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

4.5.2 General Security

i. The different areas in the hospital shall be identified either as high, medium and low security. Examples of high security areas are the entrances, stores, revenue unit, wards, delivery suites, Haemodialysis Unit and IT department inclusive of server rooms, telecommunication rooms etc.

ii. Areas identified as high or medium security shall have security measures installed and security guards placed full time. Other areas shall have a regular site patrol by the security guards.

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

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

v. Refer to:

- *SPKPK Bil.4/2006 Larangan Penggunaan Telefon Bimbit dan Telefon Selular di Hospital-hospital dan Institusi-institusi KKM* dated 23 August 2006;
- *SPKPK Bil.6/2005 Garispanduan Sistem Kawalan Keselamatan Bayi di Hospital-hospital KKM* dated 1 September 2005; dan
- *SPKPK Bil.14/2002 Garispanduan Sistem Kawalan Keselamatan di Hospital- hospital KKM* dated 20 November 2002).

- *Surat Pekeliling Am Ketua Setiausaha KKM Bil. 7/2011 – Tatacara Penggunaan Dan Keselamatan ICT KKM Versi 4.0* (2013)

4.6 Public Relations and Media Management (Public Relations)

4.6.1 Information Counter

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

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

4.6.2 Complaints and Feedbacks

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

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

iii. Common source of complaints are:

- Verbal Complaints consist of complaints received in person, through 3rd party, and via telephone communication.
- Written Complaints are complaints received through letters, faxes, e-mails, feedback forms from suggestion box and others. (*Biro Pengaduan Awam*)
- Mass Media are complaints received through newspaper, radio and television.

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

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

vi. Investigation report shall be submitted to the relevant authority within 2 weeks of receiving the complaint. Independent Inquiry report for medico-legal cases should be submitted to the Medical Practice Division within 2 weeks of the meeting.[18]

[18] *Guidelines on Management of Complaints and Medico Legal Cases, Medical Practice Division Ministry of Health Malaysia, March 2007*

4.6.3 Suggestion Box

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

4.6.4 Release of Information

i. The hospital shall not make any statement on policy matters and on issues of public interest to the public or media.[19]

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

4.6.5 Photography / Filming / Interview

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

ii. Prior consent must be obtained if the practitioner is planning to take clinical photographs or to make audio-visual/multimedia recordings. Refer to paragraph 5.1.2 on consent below and MMC Guideline on Audio and visual recordings in Medical Practice.[20]

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

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

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

4.6.6 Public Forums And Exhibition

i. Hospital shall organize talks or exhibition to provide health education to the public.

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

[19] *SPKPK Bil.13/2004 Mengenai Peraturan Membuat Kenyataan Kepada Media Massa Bercetak dan Elektronik serta Orang Ramai dated 5 November 2004*

[20] *The Malaysian Medical Council Ethical Guideline on Audio & Visual Recordings – MMC Guideline 002/2010*

4.7 Board of Visitors

4.7.1 Hospital Board of Visitors

i. The hospital shall establish a Board of Visitors[21] as required by the Ministry of Health. The Board members shall be appointed by the Minister of Health and appointed members shall be provided with an identification card.

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

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

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

v. Board members shall be invited to attend hospital functions and activities including the relevant CME session.

4.7.2 Board of Visitors for Psychiatric Hospitals / Institutions

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

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

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

4.7.3 Hospital Volunteers

i. Those who want to become hospital volunteers[22] shall apply directly to the Hospital Director and shall follow the procedure required for approval.

ii. A Medical Social Work Officer or any officers from the hospital may be appointed as coordinator. This person will be in charge in guiding the volunteers for their job scope and monitoring their services.

[21] SPKPK Bil. 2/1996 Insentif-insentif Bagi Ahli Lembaga Pelawat Hospital dated 6 July 1996 and Surat Makluman Penyelarasan Insentif-insentif Bagi Ahli Lembaga Pelawat Hospital, 2009
[22] SPKPK Bil.7/1994 Garispanduan Perkhidmatan Sukarela Di Hospital-hospital dated 13 September 1994

iii. The hospital volunteer shall abide to the hospital rules and regulations, and shall render services in professional manners.

4.8 Transport System

4.8.1 General Transport System and Ambulances

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

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

- Ambulances shall be used for pre-hospital care and for inter-hospital transportation of patients.
- Hearses shall be used for the transportation of dead bodies.
- Vans shall be used to transport supplies and materials.
- Minibuses shall be used to transport staff and ambulant patient.
- Saloon cars shall be used to transport staff.
- Lorry shall be used to transport bulk items such as furniture and equipment.

iii. Hospital vehicles shall be driven by hospital drivers[23] with valid driving licenses and shall abide to the road traffic rules and regulation at all times.

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

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

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

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

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

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

[23] SPKPK Bil. 17/2012 Penambahbaikan Garis Panduan Latihan Pemanduan Ambulan KKM, dated 16 May 2012

4.8.2 Central Porter Service

i. The central porters shall be responsible for the:

- Transfer of patients between wards and clinics
- Despatch of medical records between wards, clinic and Medical Record Unit
- Transport of pathology specimen that cannot go into the pneumatic tube for example, urine specimen, blood bags etc.

ii. The central porter service shall be available from 7am to 5 pm or as determined by the hospital management. After office hours the function shall be carried out by *Pembantu Perawatan Kesihatan* of specific wards/areas.

iii. A porter service manager shall be appointed to manage and coordinate the central porter service.

4.8.3 Pneumatic Tube System

i. Pneumatic tube shall be used to transport pathology specimens, medicines, documents and medical records, with weight according to the system specification.

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

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

iv. Hospital shall identify list of items that shall not be allowed to be transported in the pneumatic tube e.g. food, blood bag etc.

4.9 Visiting hours

4.9.1 General

i. Visiting hours shall be determined by the hospital management depending on current health situation such as H1N1 infection. Generally the visiting hours shall be as follows:

Weekdays

12.30 pm - 2.00 pm

4.30 pm - 7.00 pm

Saturday, Sunday and public holidays

12.30 pm - 7.00 pm

ii. During visiting hours, relatives shall be allowed to visit patients in the general wards.

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

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

4.9.2 Outside Visiting Hours

i. Number of visitors shall be restricted after visiting hours to only 2 visitors per patient at a time. After visiting hours any visit shall not exceed more than half an hour. All visits after visiting hours shall be recorded.

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

iii. Relatives to accompany critically ill and bed ridden patients. Only female relative shall be allowed to accompany patient in the female ward/cubicle.

iv. Mothers or guardians to accompany children in the pediatric wards.

v. Mothers of babies admitted to the special care nursery for breastfeeding.

4.9.3 Other Hospital Visitors

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

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

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

4.10 Traffic Control

i. The hospital shall implement a traffic system[24] within the hospital to avoid traffic congestion. Road to the Emergency and Trauma Department (ETD) shall only be used by ambulances and public/ private vehicles bringing emergency cases, for exit and entry.

ii. Drop-off and pick-up zone shall be provided near the entrance to the Specialist Clinic/ ETD/ Patient Admitting Center (PAC) - Labour Room for patients' convenience.

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

[24] *SPKPK Bil.10/2004 Garis Panduan Mengenai Peraturan Lalu lintas dan Meletak Kenderaan di Hospital-hospital KKM dated 15 December 2004*

CLINICAL GOVERNANCE

5. CLINICAL GOVERNANCE

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

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

- To ensure that there is a systematic framework for the health care sector for the integration of quality, safety and risk management programs to support and drive the provision of safe, effective and high quality services
- To drive core programs for quality, safety and risk management
- To ensure that appropriate accountability, leadership and oversight arrangements are in place to institutionalize and internalize quality and safety.

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

5.1 PATIENT RELATED POLICIES

5.1.1 Patients’ Rights

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

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

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

iii. The hospital shall be responsible for the safety of the patient during the hospital stay.

iv. Treatment shall be given based on patient's clinical condition. Treatment provided to patients are individualized in respect to the disease and given in a quality and safe manner.

v. The hospital shall communicate with the patient and family on the disease condition and the treatment options available. Patient and family will be involved in all decision making. Any decision made by the patient and family shall be respected.

vi. In HIS hospitals, discharge summaries are being shared through MyHIX initiatives. In this initiative, by default, patient discharge summaries are sent to MyHIX repository. However, patients have the right to OPT OUT from the programme after proper counseling given.

vii. Refer to*:*

(i) *SPKPK Bil.8/1995 Garispanduan / Peraturan Bagi Pekerja Sukarela Yang Menjalankan Aktiviti Keagamaan Di Hospital* dated 30 December 1995*,*

(ii) *SPKPK Bil.6.1992 Pengurusan Pesakit Dan Waris Mereka Semasa Berada di Hospital* dated 10 December 1992*,*

(iii) *SPKPK Bil.8/1987 Keselamatan Pesakit-pesakit Di Hospital-hospital* dated 24 June 1987*,*

(iv) *SPKPK Bil.4/1983 Pengiring Kepada Pembantu-pembantu Hospital Yang Memeriksa / Mengendalikan Pesakit-pesakit Perempuan* dated 20 August 1983.

5.1.2 Consent

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

i. Obtaining a patient's consent is a specific legal requirement and is part of good medical practice.

ii. Consent shall be obtained from the patient or next-of-kin prior to carrying out any clinical procedures. Consent shall be obtained from the patient if he / she is 18 years old or more, physically and mentally competence.

iii. In live-saving situation where all efforts to trace relatives and next-of-kin have failed, two clinical specialists, one of whom is from the related discipline can give consent for the procedure to be carried out. The consent and efforts made to trace the relatives/ next-of-kin shall be documented in the case notes.

iv. All consent must be taken by a registered medical officer or specialist performing the procedure using the consent/appropriate form. The communication includes but not restricted to:

- patient's condition
- proposed treatment/ procedure
- potential benefits and risks
- likelihood of success/ failure
- possible alternatives
- possible problems related to recovery
- possible results of non treatment

v. Among the consent / refuse of consent forms available in hospitals are:

- *Keizinan Pembedahan/Prosedur* / Consent for Operation/ Procedure PER / CONSENT / 2016
- *Surat Akuan Discaj Atas Risiko Sendiri* - Borang A[25]
- *Surat Akuan Tidak Setuju Rawatan / Prosedur* / Testimonial Letter of Refusal of Treatment / Procedure - PER/REFUSE/2016
- *Borang Keizinan Fotografi / Multimedia* / Photography / Multimedia Consent Form – PER / PHOTO/2016 (for clinical / educational purposes)

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

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

viii. 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:-

- the patient himself if he is capable of giving consent as assessed by a psychiatrist;
- 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;
- two psychiatrists, one of whom shall be the attending psychiatrist, if there is no guardian or relative of the patient or traceable and the patient himself is incapable of giving consent.

ix. For a patient below the age of 18 who required a medical treatment, consent shall be obtained as below:-

[25] *SPKPK Bil.11/2013 Prosedur Mengenai Pesakit Yang Ingin Discaj Dari Hospital Atas Risiko Sendiri dated* 12 December 2013.

a) If, in the opinion of a medical officer, the patient requires surgery or psychiatric treatment due to serious illness, injury or condition, the consent shall be given by the parents / guardian of the child / any persons having authority to consent for the treatment;

b) If, the medical officer has certified in writing that there is an immediate risk to the health of a child and medical/ surgical/ psychiatry treatment is necessary, a Protector may authorize without obtaining the consent from the parents/ guardian of the child/ any persons having the authority, but only under any of the following circumstances:-

- that the parents/ guardian of the child/ any persons having the authority to consent to the treatment has unreasonably refuse to give, or abstained from giving consent to such treatment;
- that the parents/ guardian of the child/ any persons having the authority to consent is not available or cannot be found within a reasonable time;
- the Protector believes on reasonable grounds that the parents/ guardian/the authorized person has ill-treated, neglected, abandoned or exposed, or sexually abused the child. (According to Child Act 2001, Protector is defined as the Director General, the Deputy Director General, a Divisional Director of Social Welfare, Department or Social Welfare, the State Director of Social Welfare of each of the State, any Social Welfare officer appointed).

x. In HIS hospitals, consent forms are being generated from the system and printed out for signature of relevant parties (medical/ allied health practitioner, patient/relative/guardian, witness and translator (if any)). The function of scanning and uploading of the signed document shall be made available in the system. In the era of advanced technology, digital signature shall be adopted when budget is made available.

xi. Refer to MMC Guideline on Consent for Treatment[26].

5.1.3 Counter Services

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

- Providing information
- Providing assistance
- Receiving suggestion or complaint etc.

[26] *The Malaysian Medical Council (MMC) Guideline on Consent for Treatment of Patients by Registered Medical Practitioners, 15 January 2013.*

ii. The counter shall be manned by competent persons with good public relations skill.

iii. Senior staff shall supervise the effective delivery of related counters.

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

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

- Children age one year and below
- Senior citizen (60 and above)
- Government servants and pensioners
- Blood donors (according to existing guidelines)
- Disabled persons (*Orang Kelainan Upaya*)
- Persons in custody (*Orang Kena Tahan)*

vi. Digital kiosks shall be made available in the future for the purpose of self registration, information retrieval and billing transactions.

vii. Refer to:

- *SPKPK Bil.1/2005 Garis Panduan Pengurusan Masa Menunggu di Klinik-klinik Pakar dan di Jabatan Kecemasan di Hospital-hospital KKM* dated 1 June 2005;
- *SPKPK Bil 6/2004 Langkah-langkah untuk Mengurangkan Masa Menunggu di Kemudahan-kemudahan Kesihatan* dated 20 July 2004

5.2 Appointment and Scheduling

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

ii. Online appointment / reminder of appointments shall be made available via personal / mobile devices with considerations of availability of system in hospitals and clinics.

iii. Services shall be given on an appointment basis except for Emergency and Trauma Department and General Outpatient Department.

iv. Rescheduling for early appointment, shall be upon approval by the relevant Head of Department / Units or according to policy of the Department or Unit as approved by the hospital management.

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

vi. Same day appointment- this function is made available in the system. Application of the function is upon the clinical department's policy.

5.3 Registration

i. Definition of Medical Record Number (MRN) : A number generated through the system that specifies the locality and number run in sequence.

ii. Standard MRN consists of Prefix hospital (max 6 characters) + running number (total 18 characters) eg: HKLXXX123456789012

iii. Definition of Encounter Number (EN) : Number given to the patient/client 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 eg; physiotherapy, counselling clinic and screening clinic.

iv. Patients shall be given only one medical record number (MRN) for personal identification. In all hospitals, patients are registered based on document types that comprise of MyKad, MyKid, passports (for foreigners), armed forces/ police identification cards, UNHCR cards etc. The MRN shall be used in all forms/ documents pertaining to patient care.

v. The function of on-line registration shall be made available when the need arises.

vi. There are two(2) types of registration:

- General registration for general or daily circumstances of hospital operations.
- Specific registration for specific purposes.

5.3.1 General Registration

i. Adults : All adults patients shall be registered as in 5.3 iv above.

ii. Children : Children below the age of 12 shall be registered using their MyKid or any other relevant documents.

iii. Newborns : Identification of newborn shall use mother's IC/ passport/other ID number plus prefix "E" followed by sequence of delivery. For example : second baby born to a mother with IC number : 800417035646 shall be identified as 800417035646 E02.

iv. **All newborn shall be registered and MRN given**. All stillbirths (fresh/macerated) shall be registered for clinical/ reporting/ costing (Casemix) reasons and MRN given. However, no Encounter Number (EN) shall be given to stillbirths.

v. For ill babies who need admission, Encounter Number (EN) shall be given.

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

- The transporting ambulance shall reroute to the nearest health facility and registration shall be done at the facility (government/ private).

- If the umbilical cord is cut by a hospital staff, it shall be taken into consideration as a hospital birth.
- In HMIS Statistics, PER PD 102, location of this birth is considered BBA with the name and IC of staff attending the delivery being recorded.

vii. Registration format shall be as specified by the Ministry Of Health. The staff at the registration counter shall be responsible for ensuring the completeness of the information and to ensure no duplication.

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

ix. For cases using false/fake identification, once known, the hospital staff should report to the relevant authority/police and inform the Medical Record Officer. A new MRN shall be created for that individual who has been using MRN under false/fake identification. All data under false/fake identification, needed verification by the Medical Record Officer, shall be migrated to the new MRN by ITD. The fake identity name and data shall be deleted totally after data migration.

x. Multiple registration using different document types:

In these registrations, all data shall be unified under one MRN after verification by MRO performed (merging of data).

xi. All cases in ED shall be stabilized prior to admission.

xii. In circumstances whereby patient is already registered at BDM, and deteriorate during the journey to the ward , two scenario will arise:

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

xiii. Upon registration at BDM, the officer is able to view the bed availability in HIS and able to assign bed to the patient.

5.3.2 Specific Registration

i. Disaster Registration

A standard operating procedure (SOP) need to be placed at every hospital, inclusive of Pre-Registration SOP at site of disaster if relevant.

Disaster Registration Format shall be:

Hospital prefix + D + date (ddmmyy) + disaster case identification (A) + running number:

Eg: **HTJXXX D 050314 A 0007**

If a second disaster (B) occurs within the day, then the registration shall be:

HTJXXX D 050314 B 0001.

(D denotes for Disaster Registration)

ii. Quick registration

Developed specifically for quick registration for dire emergency in ED and Patient Admission Centre (PAC).

Quick registration Format shall be:

Hospital prefix + Q + date(ddmmyy) + running number

Eg: **HTJXXX Q 050314 00007**

Q denote for Quick Registration.

iii. Unknown Registration

A temporary MRN is generated for unknown individuals ie patients without any identity available.

Unknown registration Format shall be:

Hospital prefix + U + date(ddmmyy) + running number .

Eg: **HTJXXX U 050314 00007**

U denotes for Unknown Registration.

iv. High profile/ VIP Registration

Each facility shall have their own SOP for high profile/ VIP patient registration using normal registration process. Only attending doctors/ hospital director shall have access to the patient's record following UACP.

v. Temporary registration for teleconsultation (TC) cases

In secondary and tertiary facilities, specialist and/or medical officers may receive consultation/referral via phone call or other communication methods. A temporary registration shall be made by the recipient facility.

The format of temporary registration shall be:

Hospital prefix + TC + date(ddmmyy) + running number.

Eg: **HTJXXX TC 071113 0001**.

vi. Registration during/after downtime

Each facility shall follow its own Business Continuity Plan (BCP). During system downtime, hospital may use manual pre-printed forms for registration purposes. After downtime, all manual registration shall be keyed-in into the system.

vii. On-line registration

For registered patients, on-line registration shall be made available in the future whereby patients shall be able to register themselves for the particular appointment day.

For unregistered clients, they may request appointment slot on-line, however acceptance is upon clinic's discretion.

viii. Registration of patient without person

In this situation, there will be registration and encounter without the actual person for specific purposes at the discretion of hospital director.

The format of registration shall be:

Hospital prefix + V + date(ddmmyy) + running number.

Eg: **HTJXXX V 050314 00007**

ix. Registration of external patients for investigation and procedures

For the purpose of investigation or procedures ordered at other health facilities, this function shall be made available in the system.

The format of registration shall be:

Hospital prefix + EXT + date(ddmmyy) + running number.

Eg: **HTJXXX EXT 050314 007**

x. Registration of external samples without person

This function is made available in the LIS system.

xi. Cluster registration

Registration in cluster hospitals shall have unique cluster identifier for each cluster according to cluster policy.

For cases in item i, ii and iii above, 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.

For hospital prefix, see **Appendix 7**.

5.4 Consultation

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

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

iii. The management of patients shall be documented in the designated clinical notes in manual hospitals or in Clinical Documentation (CD) of HIS.

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

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

5.5 Admission

5.5.1 Patient Admission Flow

i. Patient's admission formalities shall be carried out by the Admission Unit.All patients shall be admitted to the respective wards according to their eligibility. Patients aged 12 years and below shall be admitted to the Paediatric Ward. Patients aged 13 to 19 years shall be admitted to the Adolescence Ward if available.

ii. Stable patients from the referring hospital / health clinic can be admitted directly to the relevant ward after consultation with the ward doctor/ specialist on call. All referrals for admission shall be in accordance with existing guidelines[27].

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

iv. All cases seen at the Emergency Department shall be classified as new cases. In HIS, system shall be able to capture re-encounter within 24 hours through alert mechanism for similar or different diagnosis for the purpose of NIA/KPI of Emergency Department.

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

vi. Patients or their relatives shall pay a deposit or produce a guarantee letter on admission in accordance with the

- Fee (Medical) (Cost of Service) Order 2014; and
- Revised Circulars 'No. [44 dlm.KKM 203/20 Jld. 6] *Panduan Perlaksanaan Perintah Fi [Perubatan] Pindaan 2003 – Caj Baru Bagi Pesakit Orang Asing'.*

vii. Patients shall be transported on mobile beds, transport trolleys (incubator / cot bed / bassinet) or wheelchairs.

viii. All patient transfers must be accompanied by medical staff.

ix. In cases where the patient is not accompanied and never arrives to the ward within four (4) hours of Inpatient registration (no show to ward), the admission is considered has taken place. No cancelling of admission is allowed in this case. The ward personnel shall carry on with absconded work process.

[27] *Pekeliling Ketua Pengarah Kesihatan 2/2009; Rujukan Dan Perpindahan Pesakit Di Antara Hospital-Hospital Kementerian Kesihatan*

x. Cancellation of admission is permitted in specific situations:

- Clerical error eg. wrong person registered, transcription error.
- In cases where patient is discharged from ED and admitted to ward in the system, but deteriorated and succumbed in ED, ward admission shall be cancelled by BDM and the patient readmitted back to ED.

Cancellation can be performed by personnel in BDM as ordered by medical personnel.

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

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

xiii. Despite fully occupied ward, patients can still be admitted by creating pseudo/virtual/flexi-bed in the Hospital Information System (HIS). Physically the ward manager needs to search for extra beds.

xiv. For the purpose of statistics PER PD103, the system shall capture time upon arrival to the ward.

xv. Refer to

- *SPKPK 2/2009 Garis Panduan Rujukan dan Perpindahan Pesakit di Antara Hospital-hospital KKM* dated May 2009; and
- *SPKPK Bil.6/2001 Penyelarasan Panduan Kemasukan Pesakit ke Hospital* dated 2 April 2001.

5.5.2. Arrival at Ward

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

ii. Patient shall be ushered to the assigned bed. However the final placement of the patient is under jurisdiction of the medical personnel depending on criticality of patient. Exchanging of bed is allowed in HIS.

iii. Patient of the same sex shall be admitted in the same room or cubicle.

iv. Attending Nurse shall inform the doctors within 15 minutes for newly admitted, stable patient and shall be seen by doctors within 30 minutes.

v. Individual patient shall be provided with a bed, chair, locker and hospital clothes. Facilities like toilet, bath and rest area shall be shared.

vi. All patients who are admitted shall be given an orientation on the hospital which includes information in relation to housekeeping, ward and hospital facilities, safety instructions and information regarding data sharing (discharge summary) through MyHIX by the ward staff.

vii. Patients are advised against wearing jewelry or bringing along valuable items including large amount of cash for admission. The hospital management shall have in place a system to temporarily keep the patient's belongings or valuables, when requested by the patient. The patient shall be advised to immediately give it to the next-of-kin to bring home.[28]

viii. In-patients shall be reviewed at least once a day by a medical officer / specialist and when necessary according to the patient's clinical condition.

5.5.3 Admission / Arrival of Unknown (U) Patients (comatose, psychiatric, amnesic, etc)

i. All available information pertaining to the unknown patient admitted shall be documented into the admission book as 'unknown patient'. In HIS the doctor needs to enter clinical notes in the Clinical Documentation/ EMR.

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

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

5.5.4 Admission to First Class Wards

i. Patients shall be admitted to First Class wards when the necessary financial circulars have been complied with on a 'first come first serve' basis.

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

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

[28] *SPKPK Bil.2/2000 Garis Panduan Menguruskan Harta Benda dan Wang Tunai Pesakit dated 18 February 2000*

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

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

5.5.5 Admission to Full Paying Patient (FPP) Wards

For admission of FPP need to be referred to FPP policy and acts:

- *Perintah Fi (Perubatan) (Pesakit Bayar Penuh) 2007* [P.U.(A) 252/2007]
- *Garispanduan Pelaksanaan Perintah Fi (Perubatan) (Pesakit Bayar Penuh) 2007 Semakan 2014*

5.5.6 Dangerously Ill List Patient (DIL)

The Medical Officer / Specialist in charge of all patients deemed seriously ill shall be responsible for communicating this information to the relatives / next-of-kin in a tactful manner that is clearly understood by them. Documentation of this shall be recorded in the patient's case notes/ Clinical Documentation (CD).

5.6 Discharge

5.6.1 Planned Discharge

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

ii. Identification wristbands shall be removed at discharge (departure) except for newborn and pediatrics cases.

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

iv. All patient deemed fit for discharge shall be provided with a prescription and relevant information about their medication prior to discharge. The function of creating preliminary discharge summary is available in the HIS.

v. A diagnosis/multiple diagnoses shall be entered into the HIS before a patient is discharged.

vi. Doctors have to complete the discharge summary within 72 hours of discharge.

vii. For multidisciplinary cared patients, a combined discharge summary shall be created in HIS. The details are described at paragraph 5.9.2.2 below.

viii. All clinically discharged patient must settle their bill and official receipt shall be issued in accordance with:

- Fees [Medical] Order 1982,
- Revised Circulars 'No. [44 dlm. KKM 203/20 Jld. 6] *Panduan Perlaksanaan Perintah Fi [Perubatan] Pindaan 2003 – Caj Baru Bagi Pesakit Orang Asing'*
- Fee (Medical) (Service Cost) Order 2014

Thereafter, the process of departure can take place (discharge).

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

5.6.2 Discharged At Own Risk (AOR)/ Discharge Against Medical Advice (DAMA)

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

ii. The AOR discharge form is generated from the HIS. It has to be completed by the medical officer in charge and signed by the patient/ relatives / guardian and witness.

iii. On discharge (including AOR discharge), patients shall be provided with relevant documents related to their admission, follow up and further management e.g. discharge notes, medical certificate, appointment card etc.[29]

5.6.3 Absconded Patient

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

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

iii. If the patient remained missing after 24 hours, a police report shall be lodged.

5.6.4 Dismissal of Patients From System

The system will automatically discharge patient from the clinic at 24:00 hours (at midnight). For in-patient, similar function is made available for patients who have been discharged on the similar day.

[29] *SPKPK Bil.11/2013 Prosedur Mengenai pesakit Yang Ingin Discaj Dari Hospital Atas Risiko Sendiri dated 12 December 2013 or the latest circular enforced.*

5.6.5 Discharge Dead

If the HIS system is integrated with the Forensic system, patient movement shall be made to the mortuary and discharged from Mortuary . Otherwise, patient shall be discharged dead from the ward, and body released to the mortuary. Another registration shall be performed at the mortuary, in the FMIS if available, or manual entry otherwise.

5.6.6 Discharge Diagnosis

Discharge diagnosis/diagnoses are made mandatory in the HIS upon discharge from the hospital or facility. These diagnoses shall be in freetext documentation. Diagnoses shall be classified into Principal Diagnosis, secondary diagnoses, co-morbidities etc in tandem with Casemix MyDRG [30].

5.6.7 Discharged to Other Hospitals : Step Up / Step Down / Same Level Care

In Hospital Cluster services, patients are usually discharged to step down facilities, However discharge from a facility to a higher order care (step up) is also available.

5.6.8 Discharge Datasets for HIS

In HIS, discharge dataset shall include Discharge Home, Discharge At Own Risk, Discharge Absconded, Discharged to Step Down Care. This list is not exhaustive pending advancement in services and technology.

5.6.9 Cancellation of Discharge before 12 midnight is permitted in specific conditions:

- Clerical error eg. wrong person discharged, transcription error.
- Unexpected change of patient condition.
- Nobody to take patient home/ transport problem.

Cancellation is performed by authorized personnel in ward.

[30] *MyDRG is Malaysian Diagnosis Related Grouping, Casemix System for costing purposes.*

5.7 Death

5.7.1 Death at Hospital

i. The attending doctor in the ward or the emergency and trauma department shall carry out confirmation of death. Patients who die in the hospital shall be transferred to the mortuary accompanied by hospital personnel after one(1) hour of being pronounced dead / confirmation of death.

ii. Death that occurs at the emergency and trauma department shall be regarded as hospital Death.

iii. On confirming death, the ward/department staff shall verify the deceased status as organ donor, notify the mortuary and the next-of-kin and conduct the last office. If the next of kin is not contactable, the police shall be notified.

iv. The attending doctor, on confirming death of patient, shall register the death using the form "*Daftar Kematian / Permit Mengubur* JPN. LM02 (Pin.1/11)". This is applicable to Peninsular Malaysia. House Officers shall not be allowed to sign the above document.

v. Body of the deceased must be tagged with a body tag bearing the identity of the deceased, a white tag for cases not requiring autopsy and a red tag for cases requiring autopsy.

vi. All deaths in the hospital shall be registered at the mortuary in the Forensic Medicine Information System (FMIS) if available . Bodies shall be released to the next-of-kin or authorized person through the mortuary. All information on body release shall be documented.

vii. In the case of referred patient, the hospital shall be responsible for the transfer back of the dead body to the referring government hospital.

viii. Unclaimed bodies (non-medicolegal cases) shall be notified to the police and notices placed in newspaper after 3 days (Muslim) and 14 days (non-Muslim). The body shall be handed over to the respective religious body for burial or cremation if no claim is made after the said days following notification.

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

x. Management and handling of infectious dead bodies shall be in accordance to the standard procedures to prevent cross infection. The Health Inspector in the District Health Office shall be notified.

xi. Existing guidelines such as *Polisi dan Prosedur Kawalan Jangkitan, Kementerian Kesihatan Malaysia* and the Disinfection and Sterilization Policy and Practice 2002 shall be complied with.

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

xiii. Refer to:

- *SPKPK 5/2008 Garispanduan Penyerahan Mayat-mayat Yang Tidak Dituntut Di Hospital KKM kepada Fakulti Perubatan Universiti Tempatan bagi Maksud Pendidikan dan Penyelidikan Perubatan* dated 5 May 2008)
- *SPKPK Bil.1/1998 Garispanduan Penggunaan Format PNM1/97 Bagi Melapor Kematian Perinatal.*

5.7.2 Brought In Dead (B.I.D)

i. All B.I.D cases brought by police shall proceed to the mortuary and shall be given MRN and EN.

ii. B.I.D cases brought by families/ public shall be seen and registered in Emergency Department and be given MRN only. A police report shall be made before transferring the body to Mortuary where EN shall be generated.

iii. The police shall decide the need for forensic post-mortem examination according to the cases.

iv. For cases which require Crime Scene Investigation (CSI) as requested by the police, the Assistant Medical Officer on duty shall inform the Forensic Medicine specialist/ consultant immediately.

v. The body can be released after all the relevant procedures and documentation is done in accordance with the stipulated guidelines.

vi. Refer to SPKPK Bil.10/2012 Standard Operating Procedures Of Forensic Medicine Services.

5.7.3 Post Mortem

i. When the cause of death could not be determined, a clinical post mortem maybe requested by the specialist in charge. Consent from the next-of-kin must be obtained before a post mortem is performed.

ii. For medicolegal / police cases, the police shall be informed of the death. The police may issue a post mortem request.

iii. Post mortem shall be performed by the Forensic Pathologist or Medical Officer from the Forensic Department according to the necessity of cases. The Hospital Director (hospitals without a Forensic Department) shall determine the Medical Officer performing post mortem and he/she shall consult the state forensic expert whenever necessary.

iv. Refer to SPKPK Bil.10/2012 Standard Operating Procedures of Forensic Medicine Services.

5.8 Referral System

5.8.1 General

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

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

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

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

v. Teleconsultation (TC) shall be adopted in referral purposes, following SOP of relevant disciplines .

vi. Electronic social media consultation/referral shall abide to the MOH Social Media Policy.

vii. Existing guidelines such as "*Pekeliling KPK Bil. 2/2009: Garispanduan Rujukan Dan Perpindahan Pesakit Di Antara Hospital-Hospital KKM*" shall be complied with when referring patient.

5.8.2 Intra Facility Transfer

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

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

5.8.3 Inter Facility Transfer

i. Patient transfer is a doctor-to-doctor referral. House Officers are not allowed to refer or accept cases.

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

iii. The referring medical officer/ specialist must contact the relevant medical officer/specialist at the receiving hospital to discuss on the necessity of transferring the patient and medical doctor/ specialist must agree to accept the patient prior to the transfer taking place.

iv. If the referral is indicated but is not accepted by the doctor/ specialist (of the receiving hospital), the referring doctor shall inform his/ her superior (specialist/Hospital Director). The doctor/ specialist who refuses the referral also to inform his/ her superior (specialist/ Head of Department/ Hospital Director) and to document the reason/ decision.

v. The patient's next-of-kin shall be informed about the process of transfer. In emergency situations when a patient is unable to agree to transfer, and the next-of-kin are not contactable, the police shall be informed to help in contacting them. The responsibility for transfer rests with the doctor/ specialist in charge of the patient and the consent of the relatives is not always required.

vi. All patients shall be stabilized and deemed stable before transfer.

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

viii. All critical patients shall be accompanied by paramedics trained in resuscitation and headed by a medical officer. Accompanying staff for other cases shall be decided by the specialist/ medical officer in charge based upon the clinical condition of the patients. Monitoring of patients shall be done based on the clinical condition of the patient and recorded accordingly.

ix. Recording made in the ambulance during the transfer process, for example observation / treatment done during the journey shall be made duplicated. The duplicate copy shall be kept by the sender and original document shall be given to recipient hospital.

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

xi. A patient may be referred to the Emergency Department or directly to the appropriate ward/ care unit. The accompanying team shall have clear instructions as to their exact destination (e.g. which ward to go) prior to arrival at the receiving hospital to avoid delay.

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

xiii. If patient's clinical condition deteriorate during the transfer and resuscitation is required, the ambulance may en route to the nearest health facility or directed immediately to the Emergency Department of the receiving hospital.

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

xv. Refer to (i) SPKPK Bil. 2/2009 *Garis Panduan Rujukan dan Perpindahan Pesakit di antara Hospital-hospital KKM* dated May 2009.

5.9 Electronic Medical Records (EMR) / Documentation of Clinical Care

5.9.1 Creation of EMR

i. EMR shall be created upon registration of individuals in the facility.

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

iii. Documentation of clinical care/data entry shall be maintained by hospital personnel attending to the patient and each entry is automatically system dated and stamped.

iv. New data entry is best to be keyed–in by healthcare provider or automated flowed-in from other systems / application. Cut and paste function as a new data entry is made possible upon condition:

- Original source of information is being mentioned
- Original author is named
- Date and time of 'copy and paste' activity stamped.

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

vi. All supporting systems ie Laboratory Information System (LIS), Radiology Information System (RIS), Critical Information System (CCIS), Operation Theatre Information System (OTMS) etc shall be integrated to the main HIS.

vii. Refer para 5.9.4 for amendments and addendums in the EMR.

viii. EMR is always accessible in the system for those with access rights until 72 hours after discharge.

ix. Management of Patient Medical Record shall be in accordance to *Pekeliling Ketua Pengarah Kesihatan 17/2010 Garis Panduan Pengendalian dan Pengurusan Rekod Pesakit di Hospital-hospital dan Institusi Perubatan* dated 4 June 2010.

5.9.2 Summaries in EMR

There shall be two types of summaries depending on the services rendered ie encounter summary and discharge summary.

5.9.2.1 Encounter Summary (ES)

i. ES is defined as a summary made at the end of every encounter by the Health Care Personnel (HCP) in out-patient set-up and Day Care Services.

ii. ES shall be prepared once client completed seeing the HCP such as in Emergency Department, Day Care Services, Specialist Clinics, Rehabilitative Clinics, Diet Clinic etc.

iii. ES is auto generated once HCP dismissed client for the event. The defined content shall be auto populated in the ES. Prior to submission of the ES, the HCP shall confirm the content of ES and able to edit wherever necessary, except for the demography information.

iv. ES shall be completed on the same working day.

v. Medical Officer shall verify the encounter summary which is prepared by the House Officer. Please refer *Borang* PER-ES-2015 (**Appendix 5**).

5.9.2.2 Discharge Summary

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

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

iii. Types of discharges[31] are:

a) discharge home,

b) death,

c) absconded,

d) discharge against medical advice (DAMA), and

e) transferred out.

iv. Medical Officer shall verify the discharge summary which is prepared by the House Officer. The format is according to *Borang* PER-DS-2015. (**Appendix 6**).

v. in Multidisciplinary Care, discharge summary shall be prepared by each discipline once the patient is discharged from that particular discipline.

vi. All discharge summaries from every discipline shall be auto-populated in the final discharge summary.

vii. The doctor from the discharging discipline shall prepare the final discharge summary.

[31] *Laporan Tahunan Sub Sistem Rawatan Perubatan*

viii. The doctor shall ensure completeness of Discharge Summary by entering (key-in) Principal Diagnosis, Secondary Diagnosis, Co-morbidities, Complications etc in view of MyDRG Casemix and costings. Refer letter PIK (PER PD 301 / SKH 3 / 93 ref: KKM-BPP.PIK / 100-4 / 2/ 62 (9)).

ix. Discharge summary of deceased patient shall be prepared using the similar format of discharge summary, however information regarding death is made available.

x. Discharge summary can be accessed following User Access Control Policy (UACP). This is purely for the purpose of read-only.

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

5.9.3 Access and Sharing of EMR in HIS Hospitals

In digital technology, there are rules pertaining to access and retrieval of records. This can be referred to:

i. SPKPK Bil 13/ 2011 – *Dasar dan Garis Panduan* 'User Access Control Policy' (UACP) *bagi Sistem Maklumat Hospital dan Klinik* (HIS/CIS) *Kementerian Kesihatan Malaysia* and

ii. Personal Data and Protection Act 2010 - Act 709 to regulate the processing of personal data in commercial transactions and to provide for matters connected herewith and incidental hereto.

Data can be accessed and be shared across all borders. This includes sharing of data in facility or across facility in between government hospital and eventually between government and non-governmental facilities.

5.9.3.1 Principle to Sharing of Data

i. Confidentiality of patient data is utmost important.

ii. Weigh the benefits and risks of sharing data pertaining to patient himself or herself as an individual, to the health care provider and the organization (stakeholder/ institution/ hospital).

iii. Responsibility of the healthcare provider for data to be shared.

5.9.3.2 General Condition for Access of EMR in a Facility

i. In general, EMR can only be accessed in the following condition:
   - when the patient is enrolled in a facility
   - when the patient is referred to a facility
   - in certain cases under jurisdiction of the director of a facility, eg: for updating national registry, quality initiative activities.
   - for coding by medical record officers or other authorized personnel
   - Case to case basis, upon need-to-know for clinical purposes, only for registered medical personnel and can be audit trailed and monitored by MRO.

ii. Printing of any part of the EMR is not allowable, except:

   for referral purpose. Other exceptions are
   - consent forms to be signed manually
   - other parts of EMR with permission of hospital director, or
   - with court order
   - printing shall be done in the medical record office. However, referral letter / consent forms / specified identified documents can be printed in the ward or clinic.

iii. Hospital Director is responsible to determine clearly the access pertaining to VIP /medicolegal cases.

iv. The Custodian to the EMR shall be the Medical Record Department however access control of the EMR is under purview of IT Department as IT Administrator.

v. For inactive user of more than three months, access shall be denied by the ITD after being informed by the HOD/ HR department.

vi. Auto save function is enabled after a certain time when the system is left idle.

5.9.3.3 Purpose of Access

i. Access for Continuity of Patient Care.
   - EMR can only be accessed by all officers in the attending department. Officer from other departments cannot access the document unless referral is being made. Officers of the referred department will be given access to the referral.
   - Clinical Support Service Officers e.g: Nuclear Medicine, Forensic, Diagnostic Imaging, CSSD, Pathology, Transfusion Medicine, Rehabilitation, Physiotherapy, Audiology, Dietetics

and Pharmacy, can access demographic and clinical data of patients who received consultation in their disciplines.

- However, supporting staff e.g: staff nurses, assistant medical officers and health care assistants can only access EMR in their duty place.
- Access to EMR shall be deactivated after 72 hours (working day) patient discharged for in-patient service and after 24 hours (working day) for out-patient services.
- Sharing of discharge summary inter MOH facilities as well as with private healthcare facilities is allowed with patient consent.

ii. Access for Research and Study Purposes

Generally, the access of data in government facilities is allowed with written approval from Hospital Director and following current acts of relevant agencies. This section shall be read with reference to Chapter 9 (Research) for the details.

a) Internal Customer

- For internal customers, application should be made through the system via Medical Record Module.
- EMR access should be made under the name of the applicant with the approval of hospital director. However, the director of the hospital can appoint an officer for access right approval.
- Only specific approved EMR can be accessed by the requestor.
- The validity of Access right is only for 2 (two) weeks. For further extension new request need to be made.

b) External Customers

- External customers are defined as those who are not working at facility.
- External customer needs a written approval from the hospital director.
- A temporary access shall be given to the requestor by the system administrator.
- External customers need to comply with the research guidelines endorsed by National Medical Research Registry (NMRR) and Medical Research and Ethic Committee (MREC).

- Access duration depend on the hospital director approval in the facility.
- Access right should be automatically disabled once the research ends.
- Ministry of Health (MOH) and the higher education center (IPTA/ IPTS) shall have a Memorandum of Understanding (MOU) prior to the attachment. The details of the attachment inclusive of the level of access to the system should be delineated by respective hospital and education center upon commencement of attachment.
- Access for students is restricted to view only.
- Information sharing between MOH and other governmental agencies is allowed with mutual agreement between ministries.
- MOH and the respective agency shall have an MOU prior to data sharing.

5.9.4 Amendment of EMR

i. Amendment is defined as any changes made to the original record eg. addition, deletion and substitution.

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

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

iv. Amendments can only be performed in the presence of the client/ patient and within 72 hours of discharge.

v. Any amendment deemed necessary after 72 hour of discharge need approval from MRO with permission by the HOD. A grace period of 14 days is permitted for amendment to be made.

5.9.5 Addendum of EMR

i. Addendum is defined as addition to the EMR in any forms of data or images.

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

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

iv. After 72 hour of patient discharge, any request for addendum needs approval from MRO with permission by the HOD. A grace period of

14 days is permitted for addendum to be made.

v. There is no limit in term of quantity of addendum to be made.

vi. The types of document for the purposes of addendum shall be decided by the facility.

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

viii. System shall also capture and display reason for addendum.

ix. There shall be no amendment allowed for encounter summary or discharge summary. However, addendum is 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.

5.10 Procedure and Surgery

i. Each patient's procedure or surgery is planned and documented in the patient's case notes. Referral to the Anaesthetic Clinic will be encouraged prior to elective surgery.

ii. All consent must be taken using the consent/appropriate form prior to procedure or surgery. Refer to 5.1.2 for Consent

iii. Efforts shall be made to ensure safe surgery such as:

- The right patient
- The right procedure
- The right site

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

- Patient's details
- Consent
- Type of operation
- Site of operation

v. Documentation of surgery performed is entered into the integrated HIS/ Operation Theatre Management System. The documentation should include the name of the surgeon and assistants, post operative diagnosis, description of the surgical procedure and findings, any surgical specimen sent and post operative care plan.

vi. Refer to SPKPK 23/2009 *Pelaksanaan Inisiatif Keselamatan Pesakit*: Safe Surgery Saves Lives dated 12 November 2009; Anaesthetic Clinic Protocols, 2012.

5.11 Drug and Medication

5.11.1 Usage

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

ii. Prescription and supply of drugs not listed in the Hospital drug formulary but available in the Ministry drug formulary (blue book) shall require the respective specialist or head of department's approval.

iii. Prescription and supply of drugs not listed in the Ministry drug formulary (blue book) shall require the Ministry's approval. The respective head of the department shall be responsible for justifications of drug usage and cost implication. Request for approval shall be made using specified format and submitted through the director's office.

5.11.2 Prescription

i. Doctors shall prescribe drugs only to registered patients.

ii. Prescription performed in the Pharmacy system, eg Pharmacy Information System (PhIS) KKM, need not be transcribed in physical notes, as date and time of prescription are captured in the system.

iii. Prescription referred by the Pharmacy Department from other Ministry of Health hospitals and clinics shall be accepted. Prescription from IJN for a registered MOH patient shall be endorsed by the hospital specialist before prescription is filled, subject to availability of drugs.

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

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

5.11.3 Dispensing

i. Drugs shall be dispensed at the specified pharmacy counter.

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

iii. Bedside dispensing shall be carried out for discharged patients.

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

v. Drive-thru pharmacy counter may be established, to reduce

workload at the outpatient counter of the hospital. Other initiatives including drug by postal, dispensing the list A drug using the SBPU (*Sistem Bersepadu Pemberian Ubat*) form shall also be implemented.

5.11.4 Monitoring

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

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

iii. Refer to: (i) *SPKPK Bil.3/1990 Jawatankuasa Ubat-ubatan Negeri/ Institusi/Hospital* dated 9 April 1990.

5.12 Sterilization and Disinfection

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

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

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

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

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

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

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

5.13 Infection Control

i. Hospital Infection Control Committee shall be established to monitor and coordinate all activities related to infection control. Issues pertaining to hospital infection shall be presented to the Committee for further action.

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

iii. The team shall monitor the implementation of infection control procedures,

carry out surveillance activities, monitor antibiotic resistance pattern and conduct training of hospital staff.

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

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

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

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

viii. Infectious diseases shall be notified through the application e-Notifikasi that belongs to Infection Control Division. The two applications, HIS and e-Notifikasi shall be integrated for efficient reporting.

ix. Refer to: (i) SPKPK Bil.6/1994 Garispanduan Untuk Membuang Alat-alat Suntik, Alat-alat Tajam dan Jarum Yang Telah Digunakan Di Hospital, Klinik Dan Pusat Kesihatan Di Dalam Sektor Kerajaan Dan Swasta dated 13 September 1994,(ii) SPKPK Bil.2/1990 Guidelines On Control of Hospital Acquired Infections dated 7 February 1990

5.14 Management of Medical Records and Reports

5.14.1 Medical Records

i. Every patient receiving care in the hospital shall have individual electronic medical record (EMR).

ii. Care given and procedures done on a patient shall be keyed-in the patient's EMR. The attending doctor shall be responsible for proper entry of the patient information into the EMR.

iii. In HIS hospitals, all health care providers shall enter patient progress into the system based on their login ID.

iv. All end users of the HIS system shall abide by the User Access Control Policy (UACP)[32].

v. Limited physical documents are still available in HIS hospitals eg. referral letters, consent forms, ECG etc.

vi. Management of medical records shall be under the responsibility of the Medical Record Unit/ Department.

vii. The limited physical records shall be managed to ensure safety, confidentiality and fast retrieval.

[32] *Surat Pekeliling KPK Bil.13/2011 UACP Guidelines.*

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

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

x. Existing guideline *PKPK Bil. 17/2010: Garispanduan Pengendalian Dan Pengurusan Rekod Perubatan Pesakit bagi Hospital-Hospital dan Institusi Perubatan* shall be complied in the management of patient medical record.

xi. Medical Record for disposal should refer to PKPK Bil. 13/2016 (Pelupusan Rekod Perubatan)

5.14.2 Medical Report

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

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

iii. A medical report that has been officially released shall not be altered or tampered. Any party i.e. patient, lawyers or insurance company may request for verification when there is suspicion of tampering of the medical report. The hospital shall verify that it is 'similar' or 'not similar' to the original report released by the hospital.

iv. Medical report of medico-legal or potential medico-legal cases shall be prepared by the doctor/specialist managing the case and verified by the head of the department before release.

v. Medical report shall be charged in accordance to the Fees Act 1982/ its amendment or in accordance to the Ministries circulars. The charge is based on the complexity of report and range between RM40 – RM1000 for citizens. (New charges for non citizens refer Fee Order (Medical) (Cost of Service) 2014 and the MOH Finance circulars [33])

vi. Preparation of Medical Report should be in accordance to *Pekeliling KPK Garispanduan Penyediaan Laporan Perubatan*[34].

[33] *Surat Pekeliling Bahagian Kewangan Bilangan 1 Tahun 2014, Garis Panduan Pelaksanaan Perintah FI (Perubatan) (Kos Perkhidmatan) 2014*

[34] *"Pekeliling KPK Bil. 16/2010: Garispanduan Penyediaan Laporan Perubatan di Hospital-Hospital dan Institusi Perubatan"*

5.14.3 Medical Statistics

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

ii. The respective department and unit shall verify the statistics/ reports prior to submission to the medical record department.

iii. Request for medical data and statistics of the hospital shall be done through the medical record department and release is subject to the Hospital Director's approval.

5.14.4 Medical Board

i. Medical Board is established under eight (8) circumstances, according to *Buku Garispanduan Penubuhan Lembaga Perubatan*[35].

ii. All Medical Board application must be through State Health Office/ Hospital Kuala Lumpur (HKL)/Institut Kanser Negara (IKN).

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

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

v. The Medical Board report shall use the format as in *Buku Garispanduan Penubuhan Lembaga Perubatan*. The report must have three copies; two copies to be sent to State Health Office/ Hospital Kuala Lumpur/Institut Kanser Negara and one copy to be kept in the respective hospital. The report shall be ready within six weeks from the application date.

vi. The application for Medical Board shall be charged in accordance to the Fees Act 1982.

vii. Refer to existing guideline[36].

[35] *Buku Garispanduan Penubuhan Lembaga Perubatan35 Di Jabatan Kesihatan Negeri, Institusi Perubatan & Hospital-hospital Kementerian Kesihatan Malaysia published June 2010 page 2 and 3.*

[36] *Pekeliling KPK Bil.18/2010 Garispanduan Penubuhan Lembaga Perubatan di Jabatan Kesihatan Negeri, Institusi Perubatan dan Hospital-hospital Kementerian Kesihatan Malaysia*

5.15 Health Education

i. In HIS hospitals, health/patient education is made available in the system.

ii. The Health Education Department / Unit shall plan, coordinate, implement, monitor and evaluate all activities related to health/patient education programs in line with current MOH policies.

5.16 Ethics and Law

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

5.17 Organ and Tissue Donations

i. In accordance with *SPKPK Bil 4/2008 Pekeliling KPK BIL 4-2008 - Perkhidmatan Perolehan Organ Dan Tisu Kadaverik,* for each identified hospital, the Hospital Director shall establish Tissue Organ Procurement (TOP) Team consisting of trained personnel who shall be responsible for the identification and management of the potential donor including getting consent from the next kin, evaluation for donation, organizing the procurement, storage and transport of the organs and tissues and speedy return of the donor's remains to the next kin.

ii. All potential cases for cadaveric donations shall be made known to the local TOP Team.

iii. All deaths shall be considered for possible donations.

iv. Policies and procedures shall be made available to guide the procurement, donation process and transplantation of organs and tissues. They are consistent with the relevant laws and regulations and respect the community values, spiritual beliefs and religion (MOH – National Organ, Tissue and Cell Transplantation Policy, 2007).

MEDICAL FACILITIES

6. MEDICAL FACILITIES

6.1 Specialist Clinics

i. The clinics shall be used to provide specialist outpatient care. All specialist clinics shall operate under the supervision of the specialist in-charge and shall remain operational during office hours.

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

iii. 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.

iv. The appointment and scheduling system shall be determined by the respective hospital/department / unit in the HIS. Pre-appointment advance orders shall be made available in the system.

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

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

vii. All clients requiring services in the clinic should bring along relevant documents to facilitate appointment scheduling and registration e.g. identification documents, referral letter, appointment card, guarantee letter (e-GL) etc.

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

ix. The necessary fees related to the services provided shall be paid by the client according to the Fee (Medical) (Cost of Service) Order 2014/ other relevant revised circulars and receipts issued.

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

xi. Details of the clinic consultation shall be documented in the medical record. At the end of clinic session, patient may be either discharged, given another clinic appointment, referred elsewhere or admitted in Day Care/Wards for investigations/procedures. Types of dismissal as mentioned above shall be captured in HIS.

xii. Refer to: *SPKPK Bil.3/1985 Lawatan Pegawai-pegawai Pakar ke Hospital-hospital Daerah* dated 28 June 1985)

6.2 Emergency & Trauma

i. The hospital shall provide pre-hospital 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 of the Head of Emergency Department.

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

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

iv. All patients shall be triaged according to zones/colour; red for the critically ill, yellow for semi-critical and green for non-critical patient. Critically ill patients shall be seen immediately by the attending doctor. Quick registration function is available in the HIS for yellow and red zone patients, refer para 5.3.2 under specific registration.

v. Waiting time for the green zones shall be displayed at the Emergency and Trauma Department.

vi. Locum services shall be provided upon approval by MOH.

vii. A 23-hour ward facilities shall be considered as needed including pre-discharge lounge for patients.

viii. During a disaster, the department shall play a lead role in the management and treatment of the victims on site and in the hospital. Disaster registration is made available in the HIS, refer para 5.3.2 under specific registration.

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

x. Refer to: (i) *SPKPK Bil.4/1996 Penubuhan* One Stop Crisis Centre / *Pusat Perkhidmatan Sepadu Untuk Pengendalian Mangsa-mangsa Rogol dan Penderaan di Hospital KKM*, (ii) *SPKPK Bil.5/1993 Garispanduan Penggunaan Mercy Flight Bagi Hospital-hospital Kementerian Kesihatan* dated 17 January 1994,(iii) *SPKPK Bil.4/1990 Pengurusan Ke atas kes-kes* Head Injuries *di Hospital-hospital* dated 9 September 1990,(iv) *SPKPK Bil.5/1988 Perkhidmatan Kemalangan dan Kecemasan Di Hospital-hospital* dated 20 January 1988, (v) *SPKPK Bil.3/1989 Maklumat Untuk Orang Ramai Mengenai Penggunaan Perkhidmatan Kecemasan Di Hospital-hospital Kerajaan* dated 14 October 1989. (vii) Emergency and Trauma Services Operational Policy, 2012

6.3 Day Care

i. The day care unit shall be commonly shared/ utilized by all clinical disciplines for medical treatment, endoscopy and elective surgeries. Respective hospitals shall have a dynamic list of procedures performed as day care.Daycare services shall be provided Monday to Friday (working days) from 0700 to1800 hours (or longer if necessary).

ii. All patients scheduled for daycare services should bring along relevant documents to facilitate registration e.g. identification documents, appointment card, guarantee letter (e-GL) etc.

iii. All patients requiring daycare services need appointment and advance order which was made prior to daycare encounter. Advance orders can be made from previous admission or previous clinic encounter in the HIS.

iv. Consent shall be obtained by the attending doctor, when the doctor scheduled the case for a day-care procedure.

v. Patients undergoing day care procedures have been pre-selected and assessed and are categorized as low-risk patients. These patients shall be registered and discharged within the same day after the surgery/ procedures.

vi. Patient shall be certified fit by a medical officer before discharge; if they are deemed unfit they shall be admitted for further management.

vii. Confirmation of patient undergoing daycare procedures via phone call/ SMS/other social media must be made 24 to 48 hours prior to the procedure.

viii. Upon registration at the Day Care, fees shall be collected before procedure performed. Any changes or addition to the procedure, the difference in the cost shall be reimbursed to or paid by the patient.

ix. Billing for these patients shall be in accordance with the Fee (Medical) (Cost of Service) Order 2014/ other relevant revised circulars and official receipt issued.

x. Refer to: *SPKPK Bil.32/2010 Polisi Penyampaian Perkhidmatan Rawatan Harian di Hospital-hospital KKM* dated 15 November 2010 and Day Care Anaesthesia Protocols, 2012.

6.4 Operation Theatre

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

ii. All elective surgeries shall be carried out between 0800 to1600 hours (or longer if necessary) on normal working days according to schedule by respective department based on the allocated OT days. Additional elective

OT shall be carried out on Saturdays with an approval from MOH, in order to reduce waiting time depending on the need and availability of resources.

iii. Emergency OT shall be operational 24 hours a day; where needed a second Emergency OT shall be open.

iv. All patients undergoing elective and emergency surgery shall be assessed by the anesthetic Medical Officer or Specialist and entered into Operation Theatre Management System/ HIS.

v. All operative procedures performed shall be entered into the HIS for integrated care, reporting purposes and analytics.

vi. All procedures carried out in the OT shall comply with all existing guidelines and policies (e.g. "Guidelines on Infection Control of Hospital Acquired Infections and the Disinfections and Sterilization Policy and Practice", MOH, 2002 and *SPKPK Bil.7/2008 Perlaksanaan Pembedahan Elektif pada Hari Sabtu di Hospital-hospital Kerajaan yang Dikenalpasti* dated 7 July 2008).

6.5 Intensive Care (Critical Care)

i. Patients admitted to Intensive Care shall be cared for by the intensive care team from the Department of Anesthesiology and Intensive Care together with the primary department / unit.

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

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

iv. When continuing intensive care is deemed medically futile (brain death), end-of- life care shall be considered. This decision shall be discussed with the patient's family and with other team members as appropriate. Referrals to Organs Procurement Team shall be initiated.

v. For ill ventilated patients, the intensivist / anaesthesiologist shall discuss with the specialist of the primary department / unit whenever relatives / next-of-kin request termination of treatment and AOR discharge. Adequate explanation and the risks shall be given prior to approval for discharge.

vi. Patients on AOR discharged shall be accompanied home by a nurse. Extubation of the patient and removal of oxygen supply or drip shall be carried out by the nurse at home.

vii. In cases where relatives / next-of-kin requesting AOR discharge for ill ventilated patients to be transferred to other medical facilities, specialist shall discuss and provide adequate explanation including the risks involved

prior to approval for AOR discharge. Pre-transfer communication between the specialists of the referring and receiving unit/facility shall be done.

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

ix. Purchasing of ICU services may be allowed when the ICU beds in the hospital and nearby government facilities are not available despite compliance to "The ICU Networking Services' Guidelines, 2008. Hospital Director, Head of the primary discipline and Head of Anesthesiology and Intensive Care Department must be in agreement. Patient shall be recalled as soon as ICU bed is available within the hospital. Individual hospital shall pay for the service.

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

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

xii. The ideal nursing norm of nurse to patient ratio (1:1) according to the level of Intensive Care shall be adhered to during all shifts.

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

6.6 Mortuary

i. Mortuary services shall be provided by the hospital and headed by Forensic Medicine Specialist. In hospitals where resident Forensic Medicine Specialist is not available, the mortuary services shall be under the responsibility of a Medical Officer/Assistant Medical Officer appointed by the Hospital Director. He will be involved in the planning, management and provision of services to ensure quality and safe services are provided.

ii. The services will include but not limited to provision of body reception, body storage, body preparation area, area for viewing and bereavement and autopsy suite(where applicable).

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

iv. Electronic record shall be made available in the Forensic Management Information System (FMIS) and may include the following:

- Registration of bodies received
- Records of specimens forwarded to laboratories
- Records of all specimens and evidences taken from deceased or patients
- All relevant reports are available in FMIS

v. Where post mortem is required, the policies and procedures relating to medico legal post mortem examination must be clear, accessible and understood by staff for e.g. persons who are authorized to order post mortem examination, and proper handling of specimens as required by law. This is to ensure that the chain of evidence shall be maintained throughout the process of specimen handling.

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

vii. FMIS shall be integrated to HIS.

6.7 Laboratory

i. Laboratory services in MOH hospitals are performed in Pathology laboratories. Basic and specialized services are provided in hospital laboratories according to the category of the hospital as administratively classified by MOH. The services shall be organized and administered to provide a comprehensive and quality diagnostic service for quality and safe patient care.

ii. Department of Pathology is 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.

iii. Tests shall only be requested by an authorized personnel involved in patient management. The request shall be keyed-in into the computerized order entry (COE) in the integrated HIS / Laboratory Information System (LIS

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

v. Important step of specimen movement/process shall be entered/captured in the HIS/LIS. Automatic flow of information to / from analyzer machines is feasible in an integrated HIS.

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

vii. Specimen collection shall follow the guidelines provided by the Pathology Department. Whenever possible, automated sample delivery e.g. via pneumatic tube shall be made available. The department is responsible

to monitor the transportation condition of the samples to the laboratory to ensure quality of test results is maintained.

viii. Clinical interpretation of test result/report shall only be made by clinically qualified personnel (trained MO or Pathologist). Although the integrated HIS/LIS has alerts for abnormal test results, the laboratory shall notify the ward/clinic of test results exceeding "critical values" that are established at national level. ALL URGENT tests are to be given immediate attention, and results to be informed within the Turn Around Time (TAT) established at National Level.

ix. Out-sourcing of the tests shall be between government laboratories. If this is not possible the out-sourcing of services should be arranged with accredited or technically competent private laboratories through Pathology Department (where applicable) of the hospital.

x. Point of care testing that is technological sound may be allowed in critical care areas and other areas, for tests that are required for immediate patient management.

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

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

xiii. Refer Departmental Policy of Pathology Services in Ministry of Health Malaysia

6.8 Ancillary/ Support Services

i. All Allied Health services dataset shall be included in the HIS.

ii. According to Fee Act, no meal is allocated for Observation Rooms, Daycare and PAC.

6.9 Traditional and Complimentary Medicine (TCM)

TCM services and dataset shall be included in HIS.

QUALITY MANAGEMENT

7. QUALITY MANAGEMENT

7.1 Standard & Indicators

i. The National Indicators, Key Performance Indicators, National Key Result Areas shall be used to monitor the hospital performance in quality care.

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

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

7.2 Quality Improvement Activities

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

ii. The following quality activities shall be implemented,

- Quality assurance studies
- Quality Control Circle (KMK)
- Malaysian Patient Safety Goals
- Incident reporting
- Patient satisfaction survey
- Clients Charter
- ISO 9000 certification
- Hospital Accreditation Certification
- Clinical Audit
- 5S/EKSA
- Mortality Reviews (suspicious death, peri-operative and post-operative death, maternal mortality, perinatal and neonatal mortality, specific communicable diseases' death such as dengue, tuberculosis, leptospirosis and others in accordance to Notifiable Disease Act).

iii. All activities on quality improvement shall adhere to existing MOH guidelines and procedures (e.g. SPKPK Bil.2/1999 Ministry of Health Policy on Accreditation of Healthcare Facilities and Services dated10 June 1999)

iv. The departments and units in the hospital shall be responsible for the provision of quality and safe service.

v. The departments and units in the hospital shall establish their own standards and indicators for monitoring quality.

TRAINING

RESEARCH

8. TRAINING

8.1 Continuous Professional Development (CPD) Programme

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

ii. To maintain staff competency, which include technical, soft skill and communication skill, each personnel (both administrative and clinical) will be given the opportunity to attend training programmes in areas relevant to their functions, of not less than 7 days.

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

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

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

vi. Refer to: (i) *SPKPK Bil.4/2007 Perlaksanaan Pembelajaran Professional Berterusan* Continuing Professional Development (CPD) dated 11 July 2007)

8.2 Credentialing & Privileging

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

ii. For certain work processes in HIS hospitals, Head of Departments may appoint appropriate officers to be credentialed. The hospital director shall then endorse the credentialed officers.

iii. 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, from the Director-General of Health in accordance to Section 34C of the Medical Act 1971.

iv. Refer to (i) *SPKPK Bil.11/2008 Panduan Penggunaan Khidmat Doktor Swasta Untuk Perkhidmatan di Klinik Kementerian Kesihatan (Hospital dan Klinik Kesihatan) dengan Kadar Baru RM80 sejam* dated 24 August 2008,(ii) *SPKPK Bil.4/2001 Garis Panduan Pengambilan Pakar Swasta untuk Berkidmat di Hospital-hospital Kerajaan* dated 22 February 2001,

8.3 House Officers and Other Post-Basic / Graduate Training / Master Program and Subspecialty Training

i. A hospital that has been designated as a training centre for undergraduates / House Officers and/or other post- basic/graduate programmes is required to establish a formalized training and assessment structure relevant to the type of training being provided(refer to *Buku Panduan Program Pegawai Perubatan Siswazah Edisi 2012)*

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

9. RESEARCH

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

ii. Hospitals with an established clinical research centre (CRC) under the network CRCs, MOH shall have a structural organization and facilities to provide governance, guidance and support for research activities.

iii. All research undertaken by Ministry of Health (MOH) personnel OR conducted in MOH facilities OR funded by MOH research grant shall require:

- Prior registration with the National Medical Research Register of the MOH (online registration @ www.nmrr.gov.my)
- Prior approval by the MOH

iv. All research, as above; involving human subjects require prior ethics review and approval by the Medical Research and Ethics Committee (MREC) of MOH.

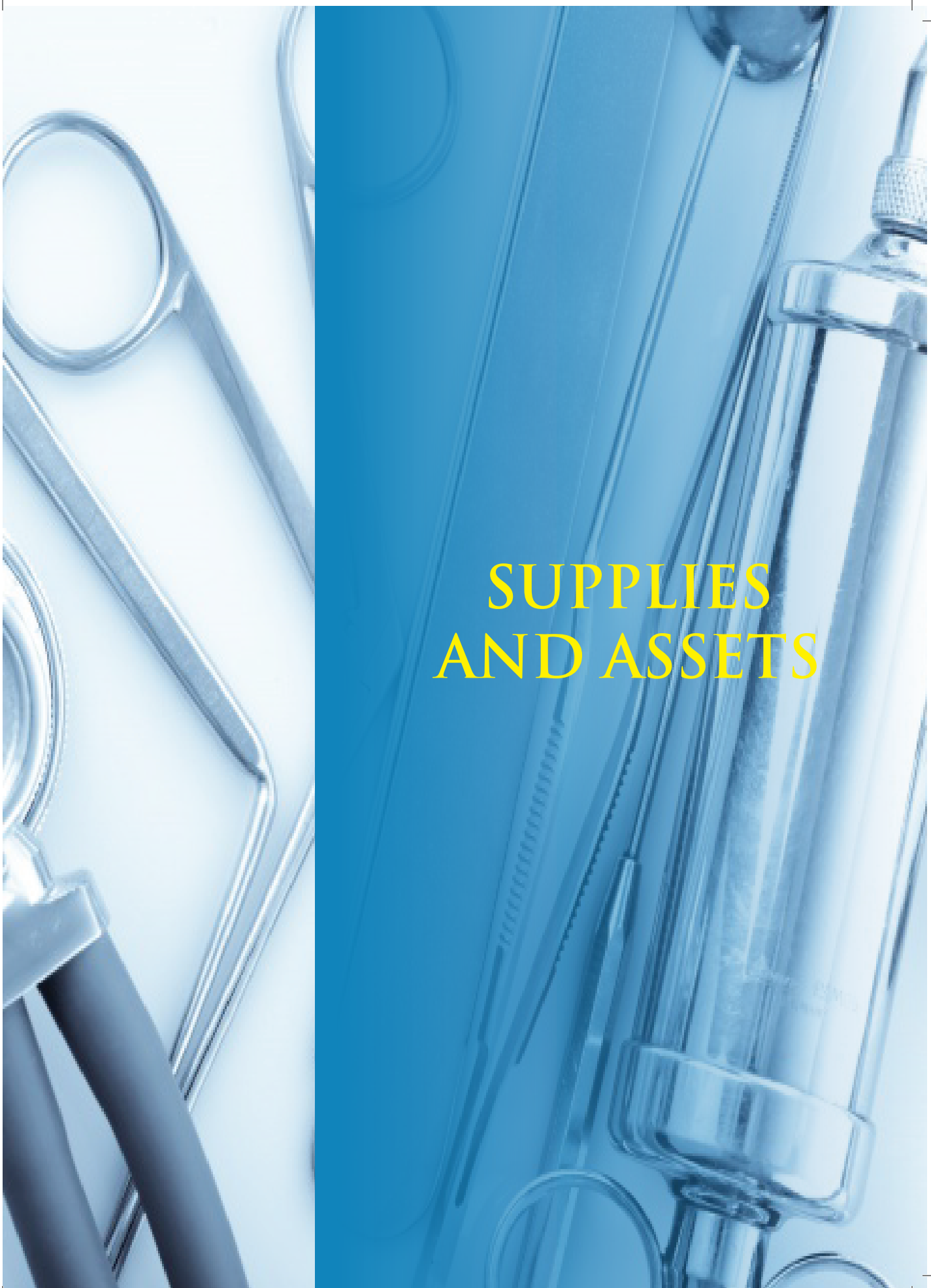
v. All publications, whether in the form of research reports, journal articles or conference proceedings, arising of research undertaken by MOH personnel OR conducted in MOH facilities OR funded by MOH research grants, shall require prior review by the NIH, and subsequent approval by the Director General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

(For (iii) – (v), please refer to *Surat Pekeliling Ketua Pengarah Kesihatan Bil. 9/2007*: "National Institutes of Health (NIH) Guidelines for Conducting Research in the MOH Institutions and Facilities")

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

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

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



SUPPLIES AND ASSETS

10. SUPPLIES AND ASSETS

10.1 Procurement

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

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

iii. Procurement of office stationeries and other non-medical items shall be coordinated by the general administration unit and IT consumables by the Information Technology unit.

iv. Purchasing of food items shall be coordinated by the catering department / unit.

10.2 Equipment and Pharmaceutical Supplies

10.2.1 Requirement & Specification

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

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

10.2.2 Delivery & Supply

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

ii. All pharmaceutical supplies shall be delivered to the medical store except for chemical reagent, which shall be sent directly to Pathology department. The supply of consumables shall be collected direct from medical store and the supply of drugs shall be collected from the ward supply pharmacy.

iii. Bulky equipments shall be delivered directly to the respective end user. The end user and the Medical Store personnel shall be present to verify the delivery.

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

v. Dangerous and Psychotropic Drugs shall be stored, transported, and

managed only by authorized staff.

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

10.2.3 Equipment / Inventory List/Loaning

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

ii. Equipment shall not be moved or transferred to another department or another hospital without prior approval of the Hospital Director. Any movement of equipment shall comply to the Guidelines on Asset Management and documented.(Refer *Para 16 Bab 6 Pekeliling Perbendaharaan Bil. 5 Tahun 2007-Tatacara Pengurusan Aset Alih Kerajaan)*

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

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

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

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

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

10.2.4 Disposal of Equipment

i. Head of department shall be responsible to submit a list of equipment to be disposed / condemned to the Finance and Account Unit.(Refer *Bab E Pelupusan -Pekeliling Perbendaharaan Bil. 5 Tahun 2007-Tatacara Pengurusan Aset Alih Kerajaan)*

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

COMMUNICATION SYSTEM

11. COMMUNICATION SYSTEM

11.1 Telephones and Fax

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

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

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

iv. Hand phones maybe be provided to certain category of staff as follows:

- Hospital Director
- Heads of disciplines
- Designated personnel on active calls
- 999 personnel on active duties
- Medical team/medical response team on duty

The provision of hand phones shall be in compliance with government directives

v. The use of mobile phones in critical areas within the hospital shall be in accordance to existing MOH guidelines.

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

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

11.2 Nurse Call System

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

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

11.3 Public Address System.

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

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

- Red alert
- Yellow alert
- Stand down
- Emergency Code such as Code Blue (Patient Collapse), Code Red (Maternal Collapse), Code Pink (Neonatal Collapse) and etc.

11.4 Social Media

Current technology in various social media applications shall be adopted as a mean of communication according to Social Media Policy.[37]

11.5 SMS

Notification through SMS eg. for appointment and scheduling and patient queue, shall be adopted.

[37] *SPKPK Bil. 10/2016 - Garis Panduan Penggunaan Media Sosial Dalam Perkhidmatan Penjagaan Pesakit di Fasiliti KKM dated 31 March 2016*

HOSPITAL AMENITIES

12. HOSPITAL AMENITIES

12.1 Car Park

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

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

iii. Refer to: *SPKPK Bil.10/2004 Garis Panduan Mengenai Peraturan Lalu lintas dan Meletak Kenderaan di Hospital-hospital KKM* dated 15 December 2004

12.2 Staff Facilities

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

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

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

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

v. Sport complex (where applicable) shall be provided for recreational purposes to staff.

12.3 Public Facilities

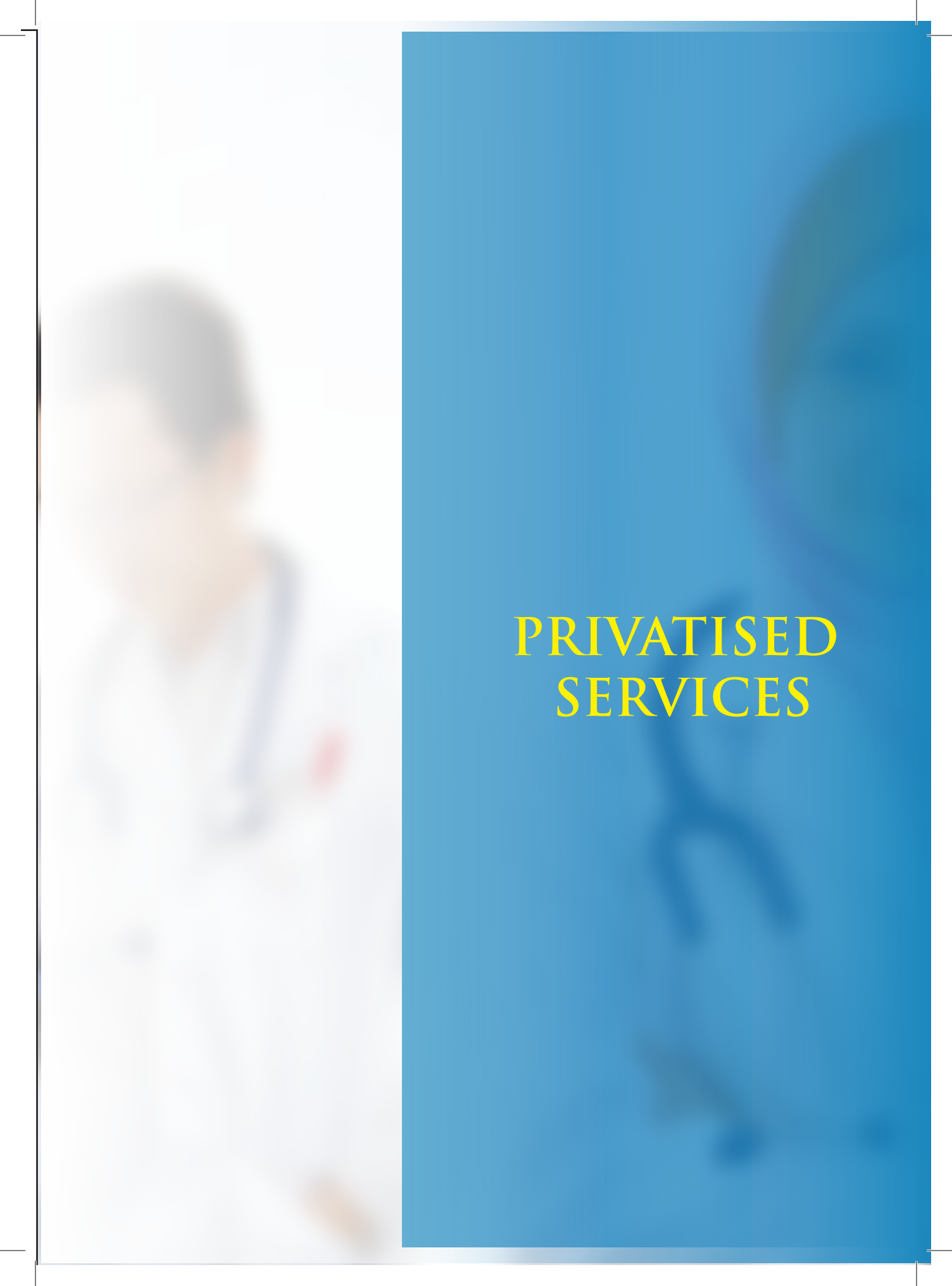
i. Public facilities shall be under the responsibility of the General Administration Unit. The following are some of the facilities available for public use:

- Balai pelawat
- Prayer rooms
- Breast feeding room
- Cafeteria
- Wash room and toilet
- Shops/kiosk
- Telephone kiosk
- Cyber café

- Auto-teller machines/banking facilities
- Post office
- Police base etc.

ii. Visitor's lounge (*Balai Pelawat*) shall be opened 24 hours as a rest place for patient's relatives. Those who use the lounge shall be subjected to the rules and regulation of the hospital.

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



PRIVATISED SERVICES

13. PRIVATISED SERVICES

13.1 Security Services

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

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

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

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

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

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

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

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

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

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

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

ix. Refer to: *SPKPK Bil.14/2002 Garis Panduan Sistem Kawalan Keselamatan di Hospital-hospital KKM* dated 20 November 2002.

13.2 Outsourced Catering Services

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

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

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

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

v. The hospital Catering and Dietetic department shall ensure:

- That raw food material received is of accepted standard and stored properly.
- Scheduled samplings of raw and cooked foods shall be collected at regular intervals and send to the Food Labs for analysis.
- That food handler are vaccinated and trained to ensure quality of food provided.
- Food preparations are in compliance with the MOH guidelines (HACCP).

Note: Meal allocation for Observation Rooms, Daycare and PAC is not stated in the Fee Act.

13.3 Hospital Support Service

13.3.1 General

i. The following 5 support services shall be privatized in accordance to the specifications in the contract prepared by the Ministry,
   - Cleansing
   - Linen
   - Waste Management
   - Biomedical Engineering
   - Facility Engineering

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

iii. The overall coordinator (Hospital Deputy Director – Management) shall have regular meetings with the liaison officers to discuss issues and remedial action to be taken to improve the services.

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

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

13.3.2 Cleansing

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

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

13.3.3 Linen Services

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

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

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

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

13.3.4 Waste Management

i. Waste shall be handled in accordance to types of wastes with standard precaution and infection control measures.

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

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

iv. "Guidelines on the Disposal of Chemical Wastes from Laboratories, 2000 by Department of Environment, Ministry of Science, and Technology & Environment, Malaysia" shall be referred to for detailed procedures in handling of chemical waste.

v. Refer to: (i) *SPKPK Bil.6/1994 Garispanduan Untuk Membuang Alat-alat Suntik, Alat-alat Tajam Dan Jarum Yang Telah Digunakan Di Hospital, Klinik Dan Pusat Kesihatan Di Dalam Sektor Kerajaan dan Swasta* dated 13 September 1994, and (ii) *SPKPK Bil.1/1992 Pengutipan Uri-uri Yang Tidak Dituntut Di Hospital-hospital KKM* dated 22 January 1992.

13.3.5 Facility & Biomedical Engineering

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

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

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

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

13.4 HIS Operation, Support and Maintenance (OSM)

i. In HIS hospitals, OSM shall be maintained by the hospital ITD.

ii. In cases of insufficient work force in ITD, the hospital shall prepare the contractual agreement under purview of Information Management Division and Procurement and Privatization Division of Ministry of Health. A contract is bound between MOH and the OSM vendor.

iii. Monitoring of OSM activities by vendor shall be performed by ITD as per contract.

iv. Planning of consumables usage shall be done by the hospital.

v. Hospital shall plan for technology refreshment and infrastructure replacement/upgrading.

DISASTER MANAGEMENT

14. DISASTER MANAGEMENT

14.1 Disaster Plan

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

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

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

iv. The Disaster Management Plan shall include the followings,

- The emergency alert system
- List of posts and responsibilities
- Medical teams
- Management of the victims
- Documentation and statistics

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

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

vii. Department and unit head shall be responsible for the disaster plan of their own department/unit. (Refer to: *SPKPK Bil.12/2001 Pelan Tindakan Bencana Untuk Hospital-hospital di Bawah KKM* dated 4 December 2001)

14.2 Hospital Evacuation

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

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

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

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

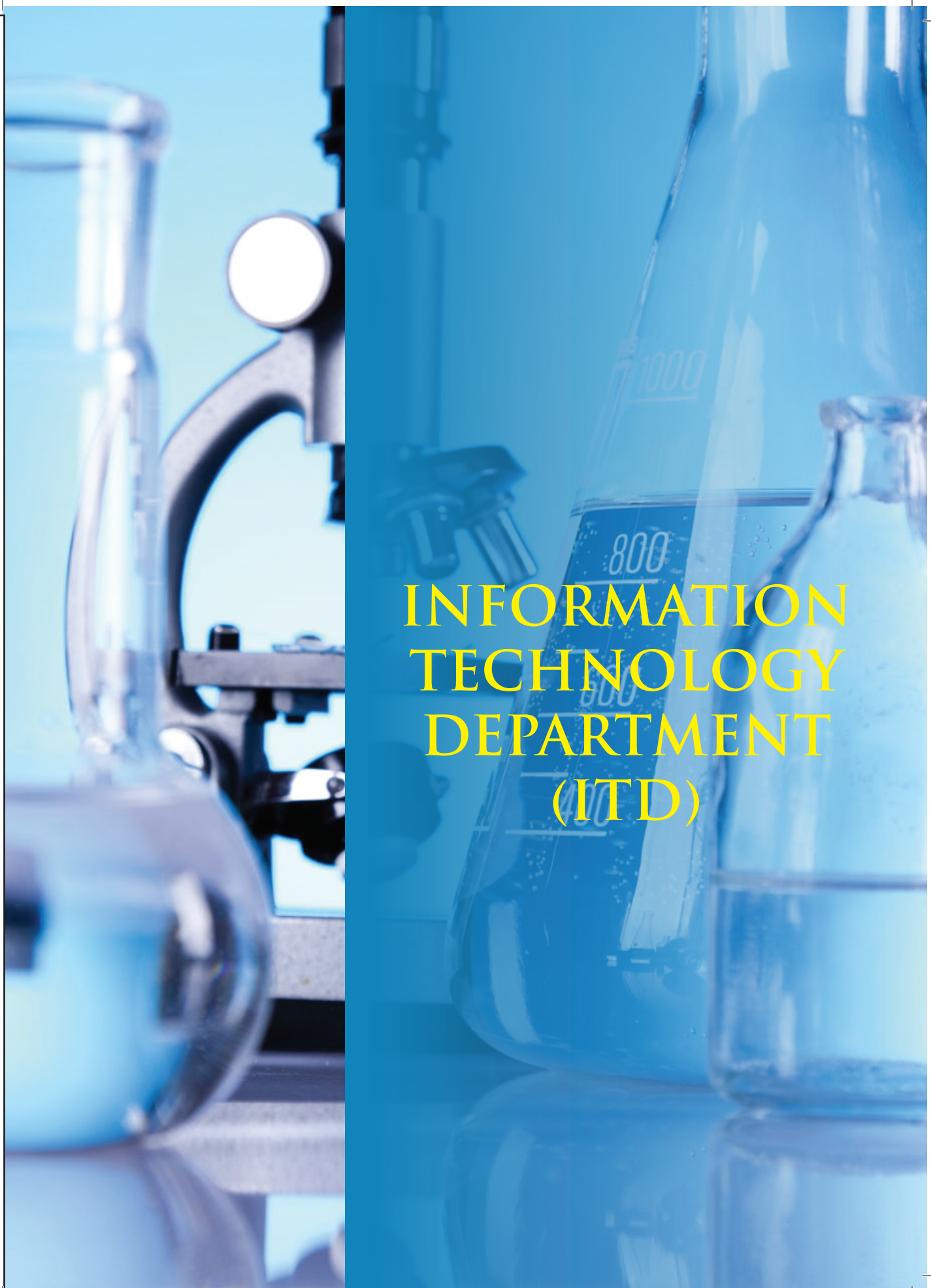
14.3 Specific Contingency Plans

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

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

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

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



INFORMATION TECHNOLOGY DEPARTMENT (ITD)

15. INFORMATION TECHNOLOGY DEPARTMENT (ITD)

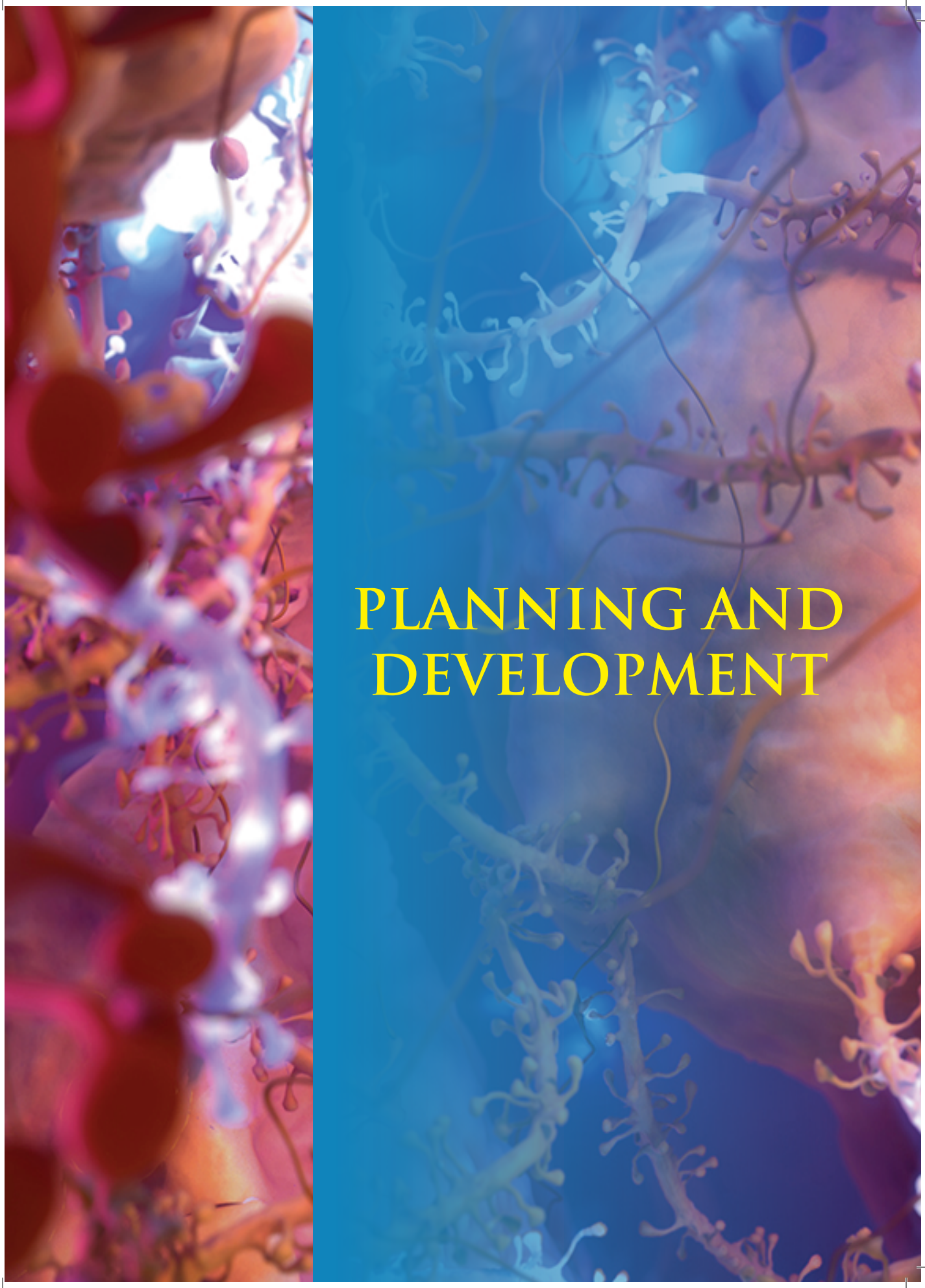
i. HIS Hospitals shall ensure that the ITD is well staffed and function according to the standards, policies and existing guidelines of the Ministry of Health and the central agencies such as MAMPU.

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

iii. Maintenance for the I.T. system shall be carried out regularly. This includes preventive maintenance for both hardware and software. Software applications and system shall require upgrading at intervals / kept current.

iv. Operation and maintenance of ICT service shall be carried out by appointed company who is accountable to ICT Department of the respective hospital. The ITD shall supervise the appointed vendor.

v. Refer to: *SPKPK Bil.13/2011 Dasar dan Garis Panduan User Acsess Control Policy bagi Sistem Maklumat Hospital dan Klinik (HIS/CIS) KKM; SPKPK Bil.1/2010 Dasar Keselamatan ICT di KKM* dated 31 March 2010. Standards include *Data Dictionary Sektor Awam* (DDSA).



PLANNING AND DEVELOPMENT

16. PLANNING AND DEVELOPMENT

i. Hospital should have master plan that describes the future needs of the service based on situational analysis done at inception / current status which shall includes services(clinical and non clinical), human resource, physical and financial requirement.

ii. MOH hospitals shall continue to be classified functionally as State Hospitals, Major Specialist Hospitals, Minor Specialist Hospitals, Non Specialist Hospitals and Special Hospitals (also known as Medical Institutions). The Hospitals shall be divided according to 6 care network regions as below:

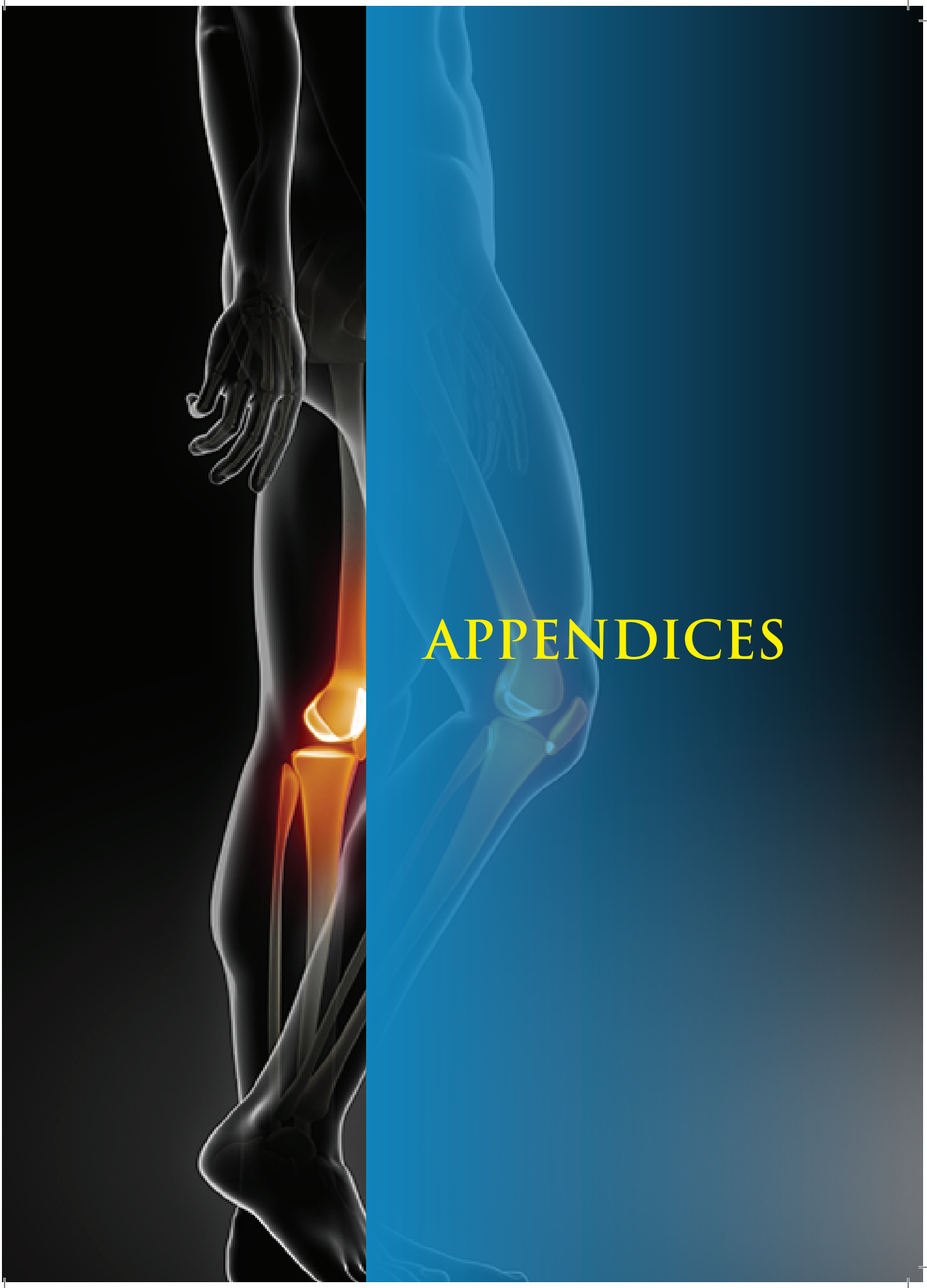
- North-Perlis, Kedah, Pulau Pinang, Northern Perak (including Ipoh)
- Central-Selangor, WP KL and Putrajaya, Negeri Sembilan and Southern Perak
- South- Johor, Melaka
- East- Kelantan, Terengganu, Pahang
- Sabah
- Sarawak

iii. Every clinical Head of Department shall plan for the service and physical development that includes short term and long term plans. The plans shall adhere to the Specialty and Subspecialty Framework of Ministry of Health Hospitals 10th Malaysia Plans 2010-2015 (December 2011) or in accordance to policies as determined by MOH.

iv. A short term planning and development plans should be developed yearly to address current needs of services and possible expansion. This shall include *Dasar Baru*/ 'One-Offs' and BP 6.

v. Planning shall be based on current existing planning norms and guidelines as determined by MOH. In the future, hospitals shall be grouped in clusters to increase efficiency and decrease underutilization of resources.

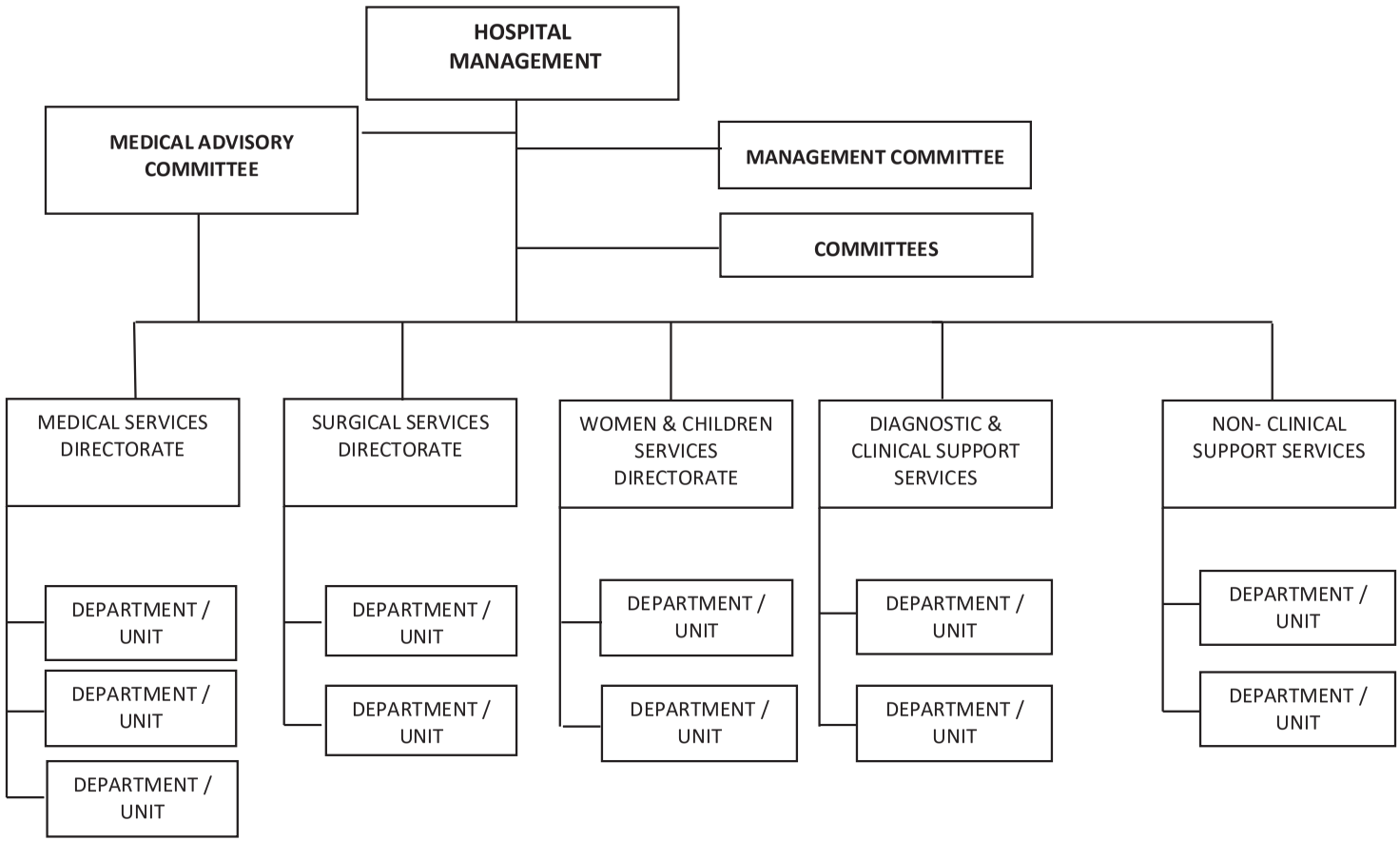
vi. Full Paying Patient (FPP) Program shall be implemented to all state hospitals in phases.



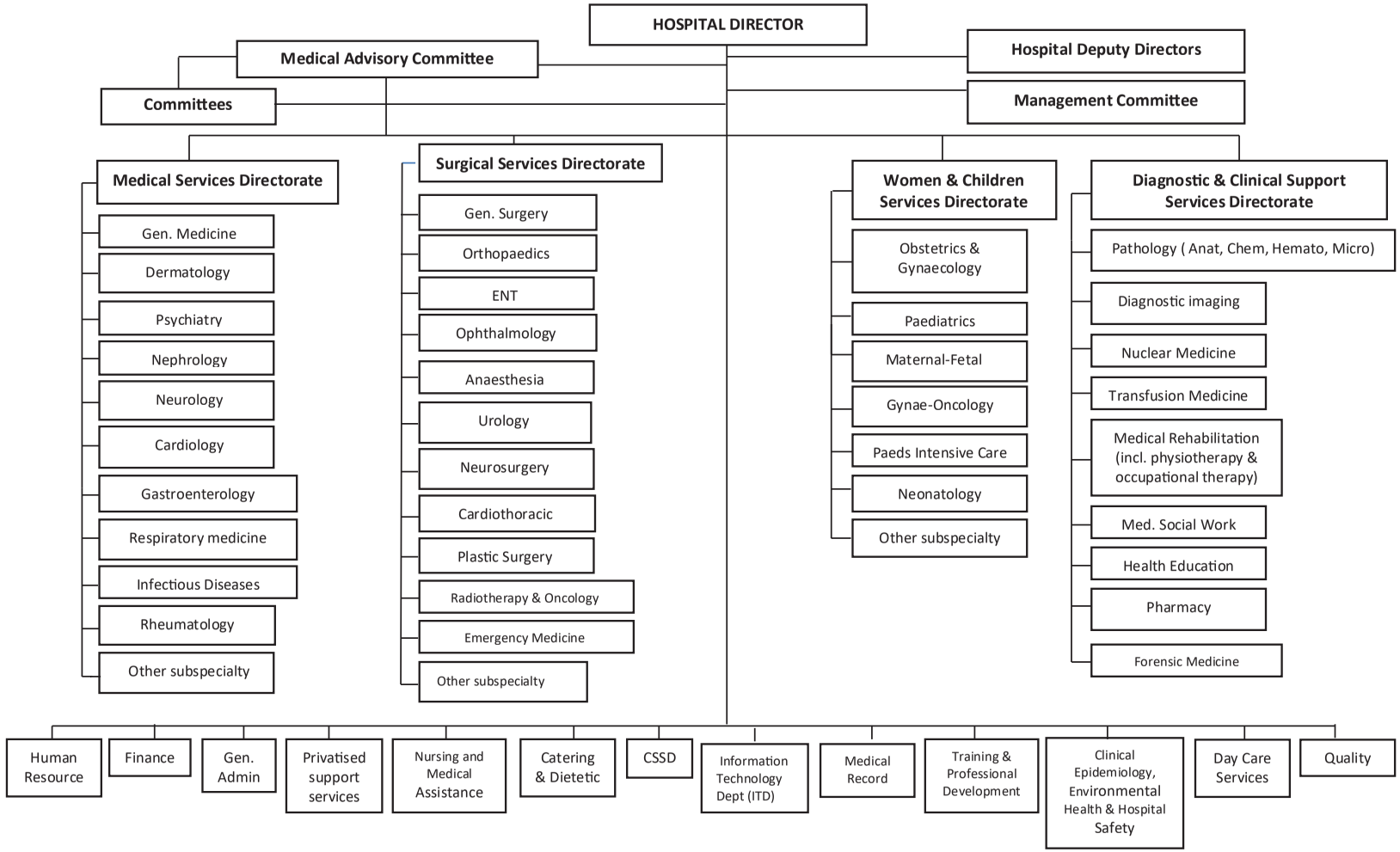
APPENDICES

17. APPENDICES

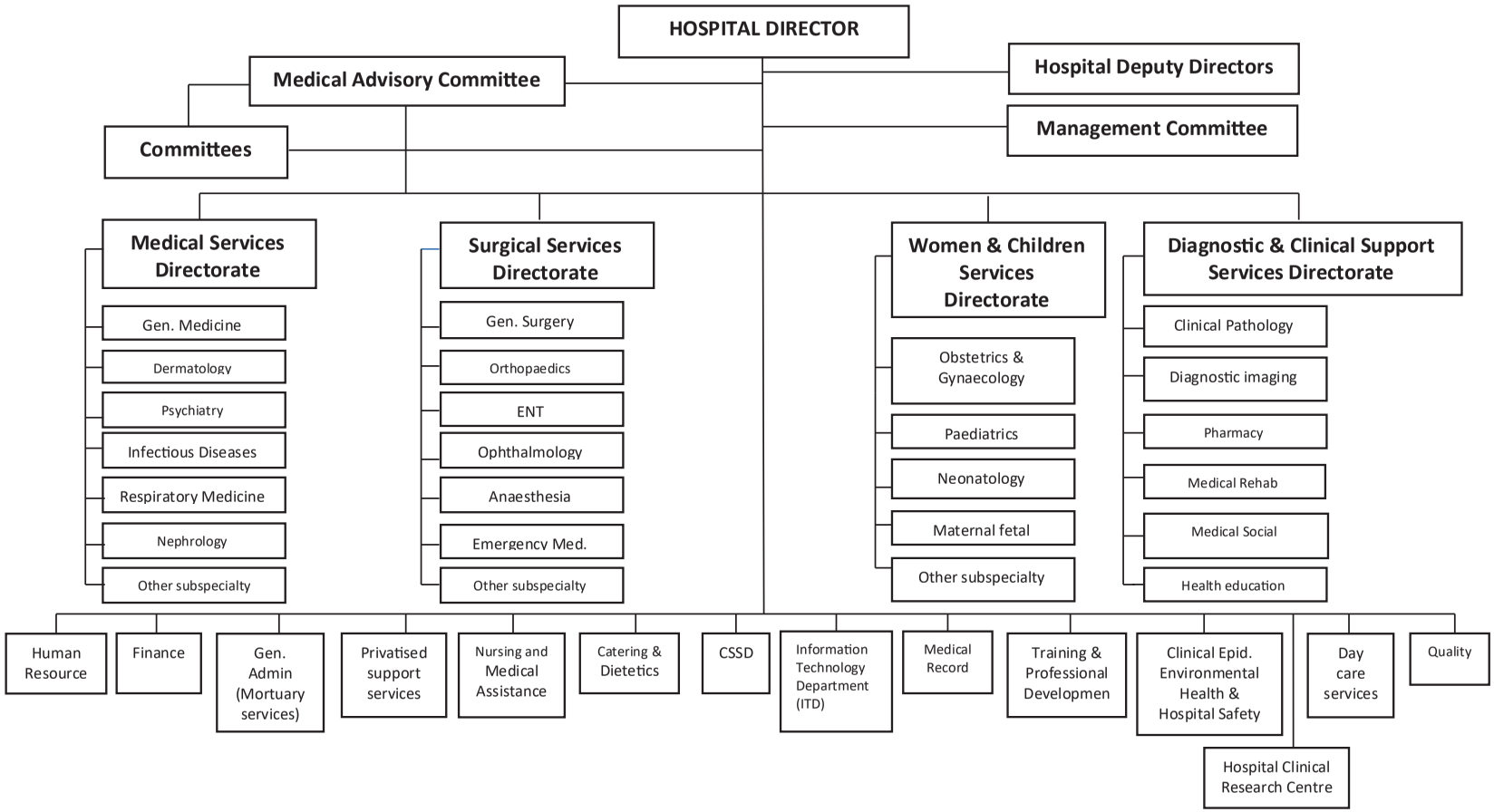
APPENDIX : 1 - HOSPITAL ORGANISATIONAL CHART



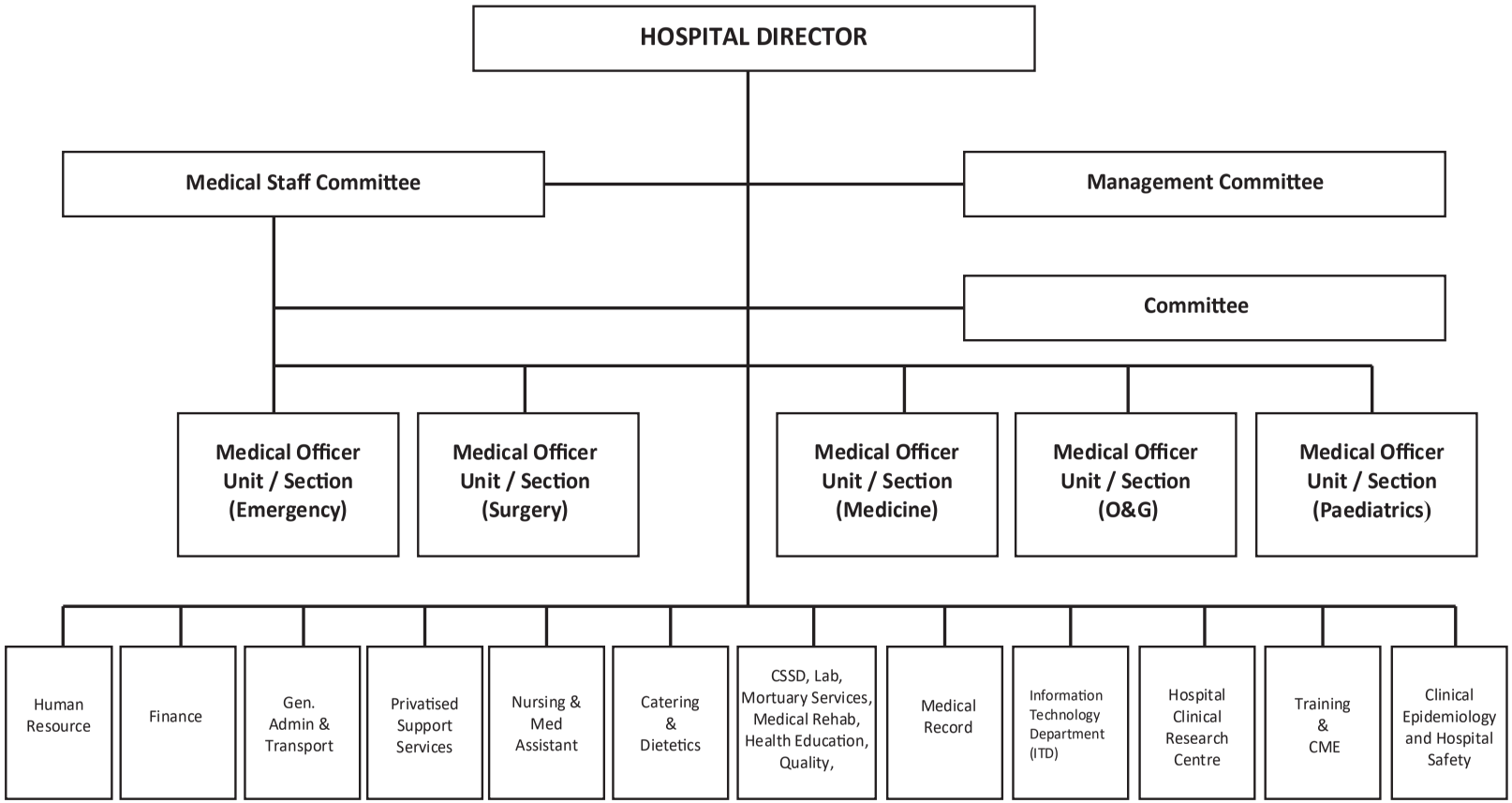
APPENDIX : 2 - ORGANISATIONAL CHART FOR STATE HOSPITALS



APPENDIX: 3
ORGANISATIONAL CHART FOR MAJOR SPECIALISTS HOSPITALS



APPENDIX : 4
ORGANISATIONAL CHART FOR HOSPITALS WITHOUT SPECIALISTS



APPENDIX: 5
ENCOUNTER SUMMARY (PER/ES/2015)

FACILITY: _____

DEPARTMENT: OUTPATIENT /EMERGENCY/SPECIALIST CLINIC/DAY CARE CENTRE/HEALTH CLINIC

<table>
<tr><td>1.NAME:</td><td>2. RN/ENCOUNTER NUMBER:</td><td>3. MRN:</td><td>4.ID NO:</td></tr>
<tr><td>5.GENDER:</td><td>6.AGE:</td><td colspan="2">7. DATE OF BIRTH:</td></tr>
<tr><td colspan="2">8. DATE OF ENCOUNTER:</td><td colspan="2">9. NAME OF CONSULTANT/HEALTH CARE PROVIDER:
a)
b)</td></tr>
<tr><td colspan="4">10.PROCEDURE:
a)
b)</td></tr>
<tr><td colspan="4">11.DIAGNOSIS:
a)
b)</td></tr>
<tr><td colspan="4">12.CLINICAL SUMMARY:
a) active problem
b) co-morbid illness
c) allergic reaction
d) result of investigation
e) medication</td></tr>
<tr><td colspan="4">13. CARE PLAN</td></tr>
<tr><td colspan="4">14.

Signature:……..

Name of Health Care Provider:……

Official Stamp:……

Date :……</td></tr>
</table>

*** RN : Encounter Number MRN : Medical Record Number**

APPENDIX: 6

DISCHARGE SUMMARY (PER/DS/2015)

HOSPITAL: _____

1.NAME	2.RN/ENCOUNTER NO	3.MRN	4.ID.NO
5.GENDER	6.AGE	7.WARD	8.DISCIPLINE
9.SOURCE OF REFERRAL:	10.DATE OF ADMISSION:	11.DATE OF DISCHARGE:	12.DATE AND TIME OF DEATH:
13.NAME OF CONSULTANS/HEALTH CARE PROVIDERS: a) b)			
14.PAST MEDICAL HISTORY			
15.PAST SURGICAL HISTORY			
16.ALLERGY HISTORY			
17.CLINICAL SUMMARY: a)Presenting complaint b)co-morbid illness c)physical examination findings d)treatment e)clinical progress f)result of investigation			
18.PROCEDURES a) b) c)			
19.ADMISSION DIAGNOSIS:		20.FINAL DIAGNOSIS / CAUSE OF DEATH a) b) c)	
21.CARE PLAN:			
22.MEDICAL OFFICER: Signature:…… Name of Medical Officer:…… MMC NO:…… Official Stamp:…… Date :……		23.Verified By Signature:…… Name of Medical Officer:…… MMC NO:…… Official Stamp:…… Date :……	

APPENDIX: 7
HOSPITAL PREFIX

Hospital	Prefix
HOSPITAL SULTANAH NORA ISMAIL, BATU PAHAT	HBP
HOSPITAL SULTANAH AMINAH, JOHOR BHARU	HSA
HOSPITAL TEMENGGONG SERI MAHARAJA TUN IBRAHIM, KULAI	HKUL
HOSPITAL PERMAI	HPR
HOSPITAL SULTAN ISMAIL, PANDAN	HIS
HOSPITAL ENCHE' BESAR HAJJAH KHALSOM,KLUANG	HKLG
HOSPITAL KOTA TINGGI	HKTG
HOSPITAL MERSING	HMSG
HOSPITAL PAKAR SULTANAH FATIMAH, MUAR	HPSF
HOSPITAL TANGKAK	HTGK
HOSPITAL PONTIAN	HPTN
HOSPITAL SEGAMAT	HSGT
HOSPITAL BALING	HBL
HOSPITAL SULTANAH BAHIYAH, ALOR SETAR	HSB
HOSPITAL SULTAN ABDUL HALIM, SUNGAI PETANI	HSAH
HOSPITAL JITRA	HJT
HOSPITAL KULIM	HKLM
HOSPITAL LANGKAWI	HLGK
HOSPITAL KUALA NERANG	HKNR
HOSPITAL SIK	HSIK
HOSPITAL YAN	HYAN
HOSPITAL GUA MUSANG	HGM
HOSPITAL JELI	HJ
HOSPITAL RAJA PEREMPUAN ZAINAB II, KOTA BAHRU	HRPZ
HOSPITAL KUALA KRAI	HKK
HOSPITAL MACHANG	HMCH
HOSPITAL PASIR MAS	HPM
HOSPITAL TENGKU ANIS, PASIR PUTEH	HTA
HOSPITAL TANAH MERAH	HTMH
HOSPITAL TUMPAT	HTU
HOSPITAL ALOR GAJAH	HAG
HOSPITAL JASIN	HJS
HOSPITAL MELAKA	HM
HOSPITAL JELEBU	HJL
HOSPITAL JEMPOL	HJP
HOSPITAL TUANKU AMPUAN NAJIHAH, KUALA PILAH	HTAN
HOSPITAL PORT DICKSON	HPD
HOSPITAL TUANKU JA'AFAR, SEREMBAN	HTJ
HOSPITAL TAMPIN	HTP
HOSPITAL BENTONG	HBTNG
HOSPITAL SULTANAH HAJJAH KALSOM	HSHK

Hospital	Prefix
HOSPITAL JERANTUT	HJR
HOSPITAL TENGKU AMPUAN AFZAN, KUANTAN	HTAA
HOSPITAL KUALA LIPIS	HKLP
HOSPITAL JENGKA	HJGK
HOSPITAL PEKAN	HPKN
HOSPITAL RAUB	HRAUB
HOSPITAL MUADZAM SHAH	HMS
HOSPITAL ROMPIN, PAHANG	HROM
HOSPITAL SULTAN HAJI AHMAD SHAH, TEMERLOH	HSHAS
HOSPITAL BALIK PULAU	HBPU
HOSPITAL SUNGAI BAKAP	HSBP
HOSPITAL BUKIT MERTAJAM	HBM
HOSPITAL SEBERANG JAYA	HSJ
HOSPITAL KEPALA BATAS	HKBP
HOSPITAL PULAU PINANG	HPP
HOSPITAL SLIM RIVER	HSR
HOSPITAL TAPAH	HTPH
HOSPITAL TELUK INTAN	HTI
HOSPITAL GRIK	HGRK
HOSPITAL PARIT BUNTAR	HPB
HOSPITAL RAJA PERMAISURI BAINUN	HRPB
HOSPITAL BATU GAJAH	HBG
HOSPITAL KAMPAR	HKPR
HOSPITAL BAHAGIA	HBUK
HOSPITAL KUALA KANGSAR	HKKA
HOSPITAL SUNGAI SIPUT	HSS
HOSPITAL SELAMA	HSL
HOSPITAL TAIPING	HTPG
HOSPITAL SERI MANJUNG	HSM
HOSPITAL CHANGKAT MELINTANG	HCM
HOSPITAL TUANKU FAUZIAH, KANGAR	HTF
HOSPITAL SELAYANG	HSLY
HOSPITAL SUNGAI BULOH	HSBH
PUSAT KAWALAN KUSTA NEGARA	PKKN
HOSPITAL ORANG ASLI GOMBAK	HOAG
HOSPITAL KAJANG	HKJ
HOSPITAL AMPANG	HAP
HOSPITAL KUALA KUBU BHARU	HKKB
HOSPITAL TENGKU AMPUAN RAHIMAH, KLANG	HTAR
HOSPITAL BANTING	HBT
HOSPITAL TANJUNG KARANG	HTJK
HOSPITAL TENGKU AMPUAN JEMAAH, SABAK BERNAM	HTAJ
HOSPITAL SERDANG	HSD
HOSPITAL SHAH ALAM	HSAS
HOSPITAL BESUT	HBST

Hospital	Prefix
HOSPITAL DUNGUN	HDGN
HOSPITAL HULU TERENGGANU	HHT
HOSPITAL KEMAMAN	HKMN
HOSPITAL SULTANAH NUR ZAHIRAH, KUALA TERENGGANU	HSNZ
HOSPITAL SETIU	HST
HOSPITAL BEAUFORT	HBFT
HOSPITAL BELURAN	HBEL
HOSPITAL KENINGAU	HKG
HOSPITAL KINABATANGAN	HKNB
HOSPITAL KOTA BELUD	HKB
HOSPITAL QUEEN ELIZABETH	HQE
HOSPITAL LIKAS	HWK
HOSPITAL MESRA BUKIT PADANG, KOTA KINABALU	HMBP
HOSPITAL QUEEN ELIZABETH II	HQEII
HOSPITAL KOTA MARUDU	HKM
HOSPITAL KUALA PENYU	HKP
HOSPITAL KUDAT	HKD
HOSPITAL KUNAK	HKN
HOSPITAL LAHAD DATU	HLD
HOSPITAL PAPAR	HPPR
HOSPITAL PITAS	HPTS
HOSPITAL RANAU	HRN
HOSPITAL DUCHESS OF KENT, SANDAKAN	HDOK
HOSPITAL SEMPORNA	HSPN
HOSPITAL SIPITANG	HSPT
HOSPITAL TAMBUNAN	HTBN
HOSPITAL TAWAU	HTWU
HOSPITAL TENOM	HTN
HOSPITAL TUARAN	HTRN
HOSPITAL BAU	HBAU
HOSPITAL BETONG	HBTG
HOSPITAL BINTULU	HBTU
HOSPITAL DALAT	HDLT
HOSPITAL DARO	HDARO
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HOSPITAL ROYAL CHARLES BROOKE MEMORIAL	RCDM
HOSPITAL SENTOSA	HSN
HOSPITAL LAWAS	HLW
HOSPITAL LIMBANG	HLM
HOSPITAL LUNDU	HLUN
HOSPITAL MARUDI	HMRD
HOSPITAL MIRI	HMIRI
HOSPITAL MUKAH	HMK

Hospital	Prefix
HOSPITAL SARATOK	HSRT
HOSPITAL SARIKEI	HSRK
HOSPITAL SERIAN	HSRN
HOSPITAL SIBU	HSIBU
HOSPITAL SIMUNJAN	HSIM
HOSPITAL SRI AMAN	HSAS
HOSPITAL KUALA LUMPUR	HKL
INSTITUT PERUBATAN RESPIRATORI	IPR
HOSPITAL REHABILITASI CHERAS	HRC
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