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WHOLE HOSPITAL POLICIES

TANDATANGAN PENYEDIA	JAWATAN	TARIKH
	DR MARDYIANA BINTI MD SEMAN KETUA PENOLONG PENGARAH KANAN (KUALITI)	15 DISEMBER 2022
TANDATANGAN PENYEMAK	JAWATAN	TARIKH
	DR REDZUAN BIN AB HAMID TIMBALAN PENGARAH HOSPITAL (PEMBEDAHAN)	15 DISEMBER 2022
TANDATANGAN YANG MELULUSKAN	JAWATAN	TARIKH
	DR. HJ MOHTAR BIN PUNGUT @ HJ AHMAD PENGARAH HOSPITAL	15 DISEMBER 2022

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HOSPITAL SULTANAH AMINAH JOHOR BAHRU

LOCATION

Johor Bahru is the southernmost city of peninsular of Malaysia. It is separated from Singapore by the Straits of Tebrau (Selat Tebrau). The Hospital Sultanah Aminah, Johor Bahru was built in 1939. It has a gazetted bed capacity of 1206 units and staff of 3818. It is a specialist hospital. The neighbouring hospitals are Hospital Sultan Ismail, Hospital Permai and Hospital Temenggong Sultan Ibrahim Kulai.

OBJECTIVE

The objective of the hospital is to provide diagnostic, curative, rehabilitative, and health promotion services that are appropriate, adequate, comfortable, efficient, effective and of the highest quality care to patients / client in order to preserve lives, reduce sufferings and achieve early and maximal recovery.

ORGANIZATION AND MANAGEMENT ASPECTS

3.1 The hospital shall be headed by the Hospital Director who is responsible for the overall management of the hospital, supported by the heads of clinical and non-clinical departments.

3.2 The Hospital management shall be aided by the various hospital committees such as Management Committee, Medical Advisory Committee, Quality Steering Committee, Health Promoting Hospital Committee, etc

3.3 All the clinical departments shall be headed by the *Ketua Jabatan* / Head of Departments. In the absence of the Head of Department, The Hospital Director may appoint the consultant or specialist of the same department in-charge to run the administration of the department till such time the Head of Department resumes duty.

3.4 The Nursing Services shall be managed by the Chief Matron (KPJ). She shall also be directly responsible for other services such as CSSD, Linen and laundry, nurses' hostel, cleanliness within the wards, infection control etc.

3.5 The Chief Assistant Medical Officer shall be responsible for co-coordinating the services provided by the Assistant Medical Officers and Hospital Attendants (Pembantu Perawatan Kesihatan) in the Hospital. In addition, he shall be directly responsible for services such as Emergency And Trauma Department's Ambulance services, Specialist Clinic, Clinical Waste Management, Facility Engineering Management Bo-Medical Engineering Management and Forensic Department. The Chief Assistant Medical Officer shall also assist the Deputy Director of Hospital in Clinical Management of the Hospital.

3.6 The Deputy Director of Hospital Administration shall be in charge of the Administration Department. He / She shall be responsible for general administration, human resource management, finance and revenue collection, development and upgrading projects, safety and security, asset and inventories, information technology, publicity and public relations, registration and admission room, etc.

3.7 Finance Department shall be managed by the *Penolong Pengarah Kewangan* and assisted by Assistant Accountant and shall be responsible for finance, assets, funding of biomedical equipment and hospital development projects, pay roll, allowances, claims, and oversee overall budgeting of Hospital.

3.8 The Hospital Support Services (HSS) which have been privatized covers facilities engineering, biomedical engineering, clinical waste management, linen and cleansing. These services shall be overseen by the (HSS) Co-coordinating Committee at the hospital level. This Committee shall be assisted by the Liaison Officers to coordinate the work process carried out by the concession company according to the contract agreement.

3.9 The overall organization of Hospital Sultanah Aminah is shown as in the chart on page 28.

3.10 The objectives, role and functions of the hospital shall be revised at least once in 3 years or revised as when needed.

3.11 The hospital management shall be responsible for engaging outsource services in accordance with Treasury Instruction, Ministry Guidelines and contract agreement.

3.12 The Hospital Privileging Committee and Manual on Credentialing & Privileging shall be established to delineate privileges of healthcare providers working in the hospital and includes:

3.12.1 Head of Department

3.12.2 Consultants

3.12.3 Specialists

3.12.4 Medical Officers

3.12.5 House Officers

3.12.6 Nurses / Assistant Medical Officers

3.12.7 Allied health professionals

HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

4.1 POLICIES

The Hospital Management shall be responsible to provide sufficient and appropriate personnel to ensure the achievement of the organization's departments / units objectives.

4.2 PROCEDURES

4.2.1 Adequate delegation of authority and appropriate personnel shall be made available.

4.2.2 Personnel policies and practices shall be established and maintained to support sound patient care.

4.2.3 Accurate and complete confidential personnel records shall be maintained.

4.2.4 Staff members are provided with a written and dated job description as well as work schedule that sets out responsibilities. Position and rostering of staff is reviewed and updated.

4.2.5 A documented staff appraisal system based on the staff member's job description shall be implemented. Annual work target will be prepared for the staff at the beginning of the year and performance will be reviewed at midyear. The performance evaluation report of each staff will be prepared at the end of the year.

4.3 STAFF DISCIPLINE

4.3.1 The Public Regulations (Conduct and Discipline), 1993 and Punch Clock System shall be adhered to.

4.3.2 Staff who are required to wear uniform shall be in uniform while on duty except when performing home visit.

4.3.3 Name Tag shall be worn while on duty

4.3.4 Staff shall not smoke within the hospital grounds.

4.3.5 All staff shall comply with the Client's Charter at all times.

4.3.6 Staff shall not involve in any business including hawking and touting within the hospital premises

4.3.7 The relevant professional codes of ethics shall be observed.

4.3.8 Staff shall render services in a professional manner and with a caring attitude in line with the Ministry of health Corporate Culture.

4.3.9 Any gifts received shall be in accordance with the existing guidelines.

4.3.10 Staff shall observe the concept of teamwork at all times.

TRAINING AND RESEARCH

5.3. The staff shall be involved in a programme for Human Resource Development provided by the management. The training programme shall include:

5.3.1 Orientation for all newly appointed staff

5.3.2 Lectures, clinical presentations and On-the-Job training

5.3.3 Refresher courses

5.3.4 Continuing Medical Education

5.3.2 The staff is encouraged to apply for post-basic courses and career development programme.

5.3.3 Research methodology shall be taught to enable staff to conduct applied research with emphasis on Health System Research techniques

5.3.4 The management shall encourage research activities in particular with clinical and operational research.

POLICIES AND PROCEDURES

6.1 ADMISSION OF PATIENTS.

6.1.1 POLICIES

6.1.1.1 Patients shall be admitted through the admission room or directly from other wards or from other hospitals. Patients shall be admitted straight to the ward from Admission Room whenever referred by the doctor from government health clinic or hospital. However, for patients who need stabilization he / she shall be attended immediately by the doctor in Emergency Department. Admission to psychiatric ward shall be done in accordance with Akta Kesihatan Mental 2001

6.1.1.2 All medical and surgical emergencies may be transferred directly from Emergency Department to the ward, and the admission formalities attended to subsequently after stabilization.

6.1.1.3 All maternity cases in labour shall be sent directly to the delivery suite and the necessary admission formalities attended to subsequently.

6.1.2 PROCEDURES

6.1.2.1 Patients or their relatives shall pay a deposit or produce a guaranteed letter from their employer or "Borang Akujanji Penjamin "on admission and settle their bills upon discharge from the hospital.

6.1.2.2 Patients shall be charged according to the Fee (Medical) Act 1982 and other regulations in force.

6.1.2.3 Patients shall be placed in a proper ward according to their class entitlement. In case of no bed available for their entitlement, he/she will be lodged temporarily in the lower-class ward.

6.1.2.4 A patient originally admitted into a ward of lower class and subsequently transferred into a ward of a higher class at his own request, shall pay all charges other than ward charges for the ward of the higher class, with effect from the day of admission into the hospital.

6.2 MANAGEMENT OF PATIENTS

6.2.1 POLICIES

6.2.1.1 All female patients examined by male medical staff shall be chaperoned by a female staff.

6.2.1.2 Special consideration for earlier examination should be given to senior citizen above 65 years old , children , pregnant mothers , Board of Visitors , Health Clinic Advisory Panels , pensioners , blood donors , police cases , psychiatry patients , staff etc.

6.2.1.3 Triaging System shall be implemented to all patients who come to Emergency Department.

6.2.1.4 Unidentified Patients (comatose , psychiatric , amnesia etc) shall be managed in accordance with existing guidelines from Ministry of Health.

6.2.1.5 Police cases and potential medico-legal cases shall be seen by the Medical Officers.

6.2.2 UNIDENTIFIED PATIENTS.

6.2.2.1 All available information pertaining to the unidentified patient admitted shall be documented in the "Unidentified Person Register " . This register shall be maintained at the Admission Room.

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

6.2.2.3 The information shall be displayed immediately on the Admission Room and the hospital public information boards .

6.2.2.4 If the patient is still unidentified after 48 hours , this information shall be disseminated by the Hospital Director through the mass media to trace the relatives.

6.2.3 MANAGEMENT OF PATIENT IN EMERGENCY DEPARTMENT

6.2.3.1 Prompt attention in patient management is according to guidelines on Color Coding System comprising of Red, Yellow and Green coded cases. Red and yellow coded cases shall be seen by the Medical Officers. Green coded cases should be screened and can be seen by the House Officer .

6.2.3.2 Management of domestic violence , rape victim and child abused and neglect should be handled at the One Stop Crisis Centre following the Ministry Guidelines.

6.2.3.3 Critically ill patients shall be managed by a multi team approach from the relevant discipline.

6.2.4 MANAGEMENT OF IN PATIENTS

6.2.4.1 Orientation of patients and accompanying relative (s) shall be done on admission for non-critically ill. Unstable and critically ill patients will be orientated when the patient is fully alert and stable.

6.2.4.2 All patients shall be clerked and examined by the doctor . Critically ill patients shall be clerked and examined immediately whereas for non critically ill patients within half an hour after admission . Patients shall be reviewed subsequently during the day and night or as frequent as required for critically ill patients.

6.2.4.3 All patients must be reviewed by the specialist at least once during their admission. All patients must be reviewed daily by the Medical Officer. Critically ill patients shall be reviewed by the specialist as soon as possible upon notice by the medical officer / paramedic or when the necessity arises.

6.2.4.4 Patients who are undergoing operation shall be tagged and reviewed by the specialists. Operation of complicated and high risk cases shall be done by the specialists.

6.2.4.5 Informed Consent shall be practiced and documented in the BHT /patient's case notes

6.2.4.6 Written consent shall be obtained :

6.2.4.6.1 From patient (s) themselves for those aged 18 years old and above

6.2.4.6.2 From next-of-kin for those below 18 years old, the disabled and psychiatric patients.

6.2.4.6.3 In the absence of the next-of-kin for dire emergency cases , the consent shall be obtained from 2 specialist ie the attending specialist and another specialist who is not involved in the patient care .

6.2.4.7 Integrated case notes with proper documentation shall be implemented by those who are involved in the management of the patients.

6.2.4.8 Discharge care plan and critical pathways shall be documented clearly for individual patient.

6.2.4.9 If the consultant specialist is absent because of leave, attending conference etc, covering specialist should be arranged by directive from Head of Department or Hospital Director .

6.2.4.10 When the head of department is not around the consultant specialist will decide on all cases requiring operations or emergency treatment.

6.2.5 MANAGEMENT OF SPECIALIST OUTPATIENTS CLINIC

6.2.5.1 Patients shall be booked for outpatient specialist's clinics or day care services according to block appointment system

6.2.5.2 Patient (s) must have referral letter from the referring doctor (s)

6.2.5.3 All patients shall be charged according to Fee (Medical) Act 1982

6.2.6 COMMUNITY SERVICES

6.2.6.1 Community Psychiatric Services shall be provided for patients up to 10 km. radius . For patients who stay near the Health Clinic , the service shall be provided by the respective assistant medical officer / public health nurse.

6.2.6.2 Community Physiotherapy Services shall be provided upon request from Community Rehabilitation Centre at the Health Clinic. This service consists of training of public health nurse and the guardian of the special child for duration of 3 months. Supervisory visits shall be conducted yearly.

6.2.6.3 Community Occupational Therapy Services shall be provided for patients with special needs.

6.3 MOVEMENT OF PATIENTS WITHIN HOSPITAL

6.3.1 POLICIES

6.3.1.1 Patient shall be transported on a mobile bed, wheelchair or trolley. Paediatric patients can be carried when necessary. The attendant is responsible for transporting patients to another department. Ambulant patient may be escorted on foot by Hospital staff.

6.3.1.2 Any patient who dies in the hospital shall be transferred on a cadaver trolley to the mortuary by the mortuary attendant.

6.4 DISCHARGE OF PATIENTS

6.4.1 POLICIES

6.4.1.1 The patient shall be discharged from the hospital in the form of normal discharge (discharge by the doctor because the patient has recovered from sickness and stable), transfer out of the hospitals for further management , patients / relatives request to refer him / her to private specialists hospital for further management , or request discharge 'At Own Risk' (AOR) for many reasons.
Patients who wish to leave the hospital against medical advice need to do so in writing in appropriate form.
AOR discharge is allowed except for cases under police custody and psychiatric cases.

6.4.2 PROCEDURES

6.4.2.1 All types of discharges shall be treated as normal discharge in accordance of Ministry of Health Guidelines where medications, health education and advice , appointment to specialists clinic or nearby Health Clinic , medical certificate , referral letter to the other hospital or clinic shall be provided by the discharging doctor of the discipline concern.

6.4.2.2 If the relative(s) decided and request to refer the critically ill patients (e.g. head injury , others) to private specialist hospital for further management, the Hospital Management shall provide Hospital Ambulance in accordance to Medical Fee Act 1982

6.4.2.3 The billings must be prepared and surrendered to the patient's or their relative / next-of-kin before the patient is allowed to go back

home or referred to other hospital .

6.5 DEATH OF PATIENTS

6.5.1 POLICIES

6.5.1.1 All types of death in the Hospital shall be managed in accordance to Ministry of Health Guidelines and all regulations in force.

6.5.2 PROCEDURES

6.5.2.1 The doctor has to certify all deaths and the Burial Permit shall be issued by the attending doctor.

6.5.2.2 The senior medical officers / specialist in the respective discipline shall lodge a police report and request to carry out a post mortem for all death that has occurred within 24 hours for unknown / suspicious cause including death during resuscitation in the Emergency Department .

6.5.2.3 The Burial permit shall be issued by the Police for " brought in dead " and "dead on arrival" . Post mortem shall be conducted upon request by the police by using P 61

6.5.2.4 CERTIFICATION OF DEATH

All deaths that occurred in the hospital shall be certified by the attending doctors to their level best of knowledge and clinical satisfaction, even though it being a medico-legal case (irrespective to the time of admission).

All suspected medico-legal cases admitted in the ward or / and died soon after; the hospital police beat-base shall be informed in facilitating further action if needed.

It is the duty of the police officer in-charge to decide on the necessity of a medico-legal post-mortem examination despite the cause of death having been ascertained by the attending doctors The same applies in a "Brought In Dead" case.

6.5.2.5 ISSUING BURIAL PERMITS AND RELATED DOCUMENTS.

The attending doctors (with the help of the medical personnel to complete the documents) shall issue the certification of death documents which includes :

a) Burial Permit.
b) JPN LM 09 / JPN LM 10.
c) JPN LM 02
d) Kad Pengenalan Jenazah (only required if the death occurs in the ward).

It shall be the responsibility of the attending doctors to check and ensure all documents and information given are true (at his / her level best of knowledge at the time of certification of death).

Housemen officers and medical students are NOT allowed to certify cause of death.

Certification of Cause of Death by the police officer in-charge is

dependent on a case by case basis (related to the Malaysia - Criminal Procedure Code).

6.5.2.6 POST-MORTEM EXAMINATION OF THE DECEASED

All post mortem examinations of the deceased shall be managed in accordance with Ministry of Health Guideline on Post Mortem Examination; MOH/P/PAK/170.08 (CL).
Medico-legal post-mortem examinations will be officially carried out by the doctors in the Forensic Medicine Department (Polis 61 Form issued by the Police Officer In-charge).

Clinical post-mortem examination will be officially carried out by the doctors in the Pathology Department (written consent from the relatives is essentially required). The attending doctors from the respective ward(s) / department(s) shall discuss the necessity of the matter with the next-of kin beforehand.

Post-mortem examination shall NOT be conducted after 9 pm (exception being with permission from the Head of Department of Forensic Medicine Department). If the Polis 61 Form is issued and received by the Forensic Medicine Department after this time, it shall be advised for postmortem examination to be postponed to the next day.

6.6 REFERRAL SYSTEM

6.6.1 POLICIES

6.6.1.1 All referrals shall be in accordance with existing guidelines as stated in the "Garispanduan Rujukan Kementerian Kesihatan Malaysia " .

6.6.2 PROCEDURES

6.6.2.1 Patients who need further specialized treatment shall be referred to other government specialist hospital where the ambulance charges will be covered by the hospital . Patients who request to be referred to other private specialist hospital for second opinion the hospital shall provide the hospital ambulance service; however the ambulance charges must be paid first by the relative before leaving the hospital .

6.6.2.2 Patients who require extended medical care shall be referred to the special services such as palliative care , occupational therapy , physiotherapy etc .

6.6.2.3 Verbal notification to the receiving hospital shall be done by the doctor in the respective discipline .

6.6.2.4 All types of cases that need further referral to Regional Hospital (e.g : Kuala Lumpur , Selayang Hospital and National Heart Institute) shall be referred with permission from the respective hospital .

6.6.2.5 Inter departmental referrals shall be informed by the doctor in the respective discipline.

6.7 VISITORS AND VISITING HOURS

6.7.1 POLICIES

6.7.1.1 Visiting hours are scheduled as follows:

6.7.1.1.1 First visiting session:

- 12.30 pm to 2.00 pm

6.7.1.1.2 Second visiting session:

- 4.30 pm to 6.30 pm

6.7.1.1.3 Visiting session for Intensive Care Unit:

- 4.30 pm to 6.30 pm.

6.7.2 PROCEDURES

6.7.2.1 Close relatives of critically ill patients shall be issued with color coded visiting passes outside visiting hours. The number of visitors is limited to two persons per patient at any one time.

6.7.2.2 Mothers or female relatives shall be allowed to accompany children in pediatric wards. Fathers or close male relatives shall be allowed to accompany children in pediatric wards during the day.

6.7.2.3 Mothers of babies in the Special Care Nursery shall be encouraged to stay in the mother's room for breast feeding and interaction whenever possible.

6.7.2.4 At any time, only 2 color coded passes per patient shall be issued by the security guard for this purpose. The duration of the visit is limited to 20 minutes.

6.7.2.5 During non -visiting hours, visiting privileges shall be at the discretion of the doctor-in-charge of the patient or the ward sister or staff nurse-in-charge of the ward depending on patient's general condition.

6.7.2.6 Children below 12 years shall not be allowed to visit inpatients. Special visiting privileges to be given when required.

6.8 CLINICAL

6.8.1 POLICIES ON CLINICAL MANAGEMENT OF PATIENT

6.8.1.1 Management of inpatients and outpatients shall follow the Clinical Practice Guidelines, Clinical Protocols and Clinical Procedures.

6.8.2 PROCEDURES AND PROTOCOLS

6.8.2.1 Protocols and Procedures shall be developed by departmental heads for :

6.8.2.2.1 Clinical Management of cases

6.8.2.2.2 Clinical Emergency

6.8.2.2.3 Work Procedures

6.8.2.2.4 Disaster Management

6.9 INFECTION CONTROL

6.9.1 POLICIES

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

6.9.1.2 Cross-Infection precautions shall include frequent hand washing and the use of gowns by anyone having direct contact with an Infectious patient .

6.9.1.3 Hand-wash basins with elbow action taps shall be provided in all patients areas.

6.9.1.4 Soiled instruments shall be counted before being deposited into respective containers . Soiled linen shall be deposited into respective bags to be collected and weighed by the Hospital Support Service personnel .

6.9.1.5 All instruments and linen used by infectious patients shall be double bagged immediately in special bags (without soaking) and sorted only after decontamination . All clinical waste from infectious patients shall be double bagged in yellow plastic bags for disposal by incineration.

6.9.1.6 For known AIDS and cholera patients or carriers who die in the hospital the last offices shall be carried out in the mortuary under the supervision of the Public Health Inspector .

6.9.1.7 Existing guidelines such as , "Guidelines on the Control of Hospital Acquired Infections " and the Disinfection and Sterilization Policy and Practice ' shall be complied with.

6.9.1.8 The Infection Control officer shall provide advice and guidance on the proper method of collecting specimens , precautions in preventing transmission on infection , training of hospital staff , and inform the Hospital Infection Control Committee of problems related to the control of infection .

6.9.1.9 All notifying diseases as listed in the Notifiable Disease Act shall be notified by telephone immediately to the health Office followed by the dispatching of the required format within 24 hours.

6.10 STERILIZATION

6.10.1 POLICIES

6.10.1.1 The Hospital management shall be responsible to provide sterilization services to the respective department or unit in the hospital

6.10.2 PROCEDURES

6.10.2.1 Sterilizations of all instruments and materials that need sterilizing shall take place in the Central Sterile Supply Unit , apart from the following

6.10.2.1.1 Short cycle sterilization shall be made available for the use of operating theatre and dental clinics only .

6.10.2.1.2 Sterilization of bottles shall take place in the milk kitchen

6.10.2.1.3 Sterilization of pharmaceuticals shall take one place in the Pharmacy Unit.

6.10.2.1.4 Sterilization of media , glassware and infected specimens shall take place in the Pathology Unit.

6.11 WASTE MANAGEMENT

6.11.1 POLICIES

6.11.1.1 The Hospital Support Service shall be responsible to manage the waste management through out the hospital

6.11.2 PROCEDURES

6.11.2.1 A senior staff member shall be identified to train staff on how to handle waste and monitor standards.

6.11.2.2 The Infection Control Officer (usually the Micro-biologist or Infection Control Personnel) shall provide advice and guidance on safe practice and procedures for handling clinical waste.

6.11.2.3 Hospital waste is categorized as clinical waste , radioactive waste , chemical waste , pressurized containers and general domestic waste . It shall be collected by private workers from the disposal room and transported to the respective central points.

6.11.2.4 All clinical waste is considered as hazardous and shall be placed in yellow bags or containers . It shall be sealed upon three quarters (3/4.) full and collected for incineration daily . The methods of disposing the different types of clinical waste are :

6.11.2.4.1 ***GROUP A***

Soiled surgical waste , dressing , swabs , human tissues , etc , shall be placed in yellow plastic bags . Waste from infectious cases and human tissues such as placenta should be placed in double plastic bags.

6.11.2.4.2 ***GROUP B***

Sharps shall be placed in sharps containers and upon three quarters (3/4.) full , sealed and placed into yellow plastic bags.

6.11.2.4.3 ***GROUP C***

Waste from laboratories and post-mortem rooms that are potentially infectious , shall be disinfected before disposing into yellow plastic bags. If necessary, the waste may be placed in a light blue plastic bags for autoclaving and then sealed in yellow bags for disposal.

6.11.2.4.4 ***GROUP D***

Soiled pharmaceutical waste , shall be placed in yellow plastic bags and disposed of by incineration unless recommended otherwise by the manufacturer e.g. for chlorates. Small quantities of liquid pharmaceutical waste may be diluted and disposed of through the sewerage system . Cytotoxic waste and associated contaminated materials (needles , vials , etc.) shall be placed in designated containers and must be put into yellow plastic bags for incineration.

6.11.2.4.5 ***GROUP E***

Used disposable bedpan liners , stoma bags , incontinence pads etc shall be placed in yellow plastic bags.

6.11.2.5 The collection , storages and transportation of radioactive waste shall comply with the requirements of the Atomic Energy Licensing Act 1984

6.11.2.6 Chemical waste may be hazardous (toxic, corrosive , flammable , reactive) or non-hazardous. :

♠ Hazardous chemical waste shall be disposed off by the most appropriate means according to the nature of the hazard . Because it often has toxic or flammable properties , hazardous chemical waste shall be disposed of in
the sewer system.

♠ Non-hazardous chemical waste may be disposed of along with general waste.

6.11.2.7 Pressurized containers shall be placed in black plastic bags and disposed off as general domestic waste.

6.11.2.8 General waste may be non-hazardous (paper , food , plastic , etc.) or hazardous (glass , chinaware , knives , tubes , light etc.)

♠ Non-hazardous general waste shall be place in black plastic bags and disposed off by the local authority.

♠ Hazardous general waste requires special handling . Light bulbs and fluorescent tubes shall be collected unbroken by the local authority.

6.11.2.9 Private / pooled workers shall not handle waste in unsealed or open bags and waste in light-blue bags (prior to autoclaving).

6.12 SUPPLIES POLICIES

6.12.1 POLICIES

POLICIES ON MOVEMENT AND PROCUREMENT OF SUPPLIES

6.12.1.1 The Hospital Management shall provide sufficient supply to all departments and units in accordance to the guidelines

6.12.2 PROCEDURES

6.12.2.1 Movement of supplies shall be done by department / unit's Pembantu Perawatan Kesihatan . Dedicated workers from the following departments shall be responsible for transporting their respective supplies

♠ Pharmacy / store (deliver supplies for scheduled indents only)

♠ CSSU (deliver clean and collect used CSSU packs to the specialized wards and unit only) .

♠The portering system is encouraged so that activities within the wards can be carried out more efficiently.

6.12.2.2 For urgently needed supplies , departmental staff shall be responsible for collecting them .

6.12.2.3 Procurement of supplies shall be the responsibility of the following departments :

♠ domestic and medical supplies by the medical store
♠ office supplies and stationery by administration

♠ food supplies by the Unit Sajian /

kitchen

6.12.2.4 A proper inventory shall be kept by all departments / units

6.13 STERILE SUPPLIES

6.13.1 POLICIES

6.13.1.1 The Hospital Management shall provide sufficient sterile supply to all departments and units to ensure the efficiency and effectiveness of service of that department or unit.

6.13.2 PROCEDURES

6.13.2.1 The wards and department / units shall exchange and replace used CSSU supplies with sterile medical instruments and sterile linen on a regular basis

6.13.2.2 The medical store shall supply commercially sterilized supplies to the units concerned on receipt.

6.14 PHARMACY SUPPLIES

6.14.1 POLICIES

6.14.1.1 The Hospital Management shall be responsible to supply medicines , disposable and non disposable items to the respective department / unit to ensure the objective and goal of the department is achieved.

6.14.2 PROCEDURES

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

6.14.2.2 The pharmacy shall supply the wards and departments with additional stock items on an indent basis

6.14.2.3 Medication prescribed after office hours and not available in ward stock shall be indented from the Satellite Pharmacy at the Hospital Induk and Block , and if not available, shall be collected from the Pharmacy by on call- basis

6.14.2.4 The controlled drugs cupboard shall be topped-up by the pharmacist on a regular basis e.g twice weekly upon request from the ward / unit.

6.14.2.5 All prescriptions for inpatient discharges, specialist clinics and Emergency Department during office hours shall be dispensed by the Pharmacy Department. Prescriptions from Emergency Department outside of office hours shall be dispensed by itself with medication sufficient only to last till the next working day .

6.14.2.6 Drugs prescribed to hospital patients shall be in accordance to the approved list of drugs issued by the Ministry of Health

6.14.2.7 All prescriptions shall be written by a doctor using generic names.

6.14.2.8 Supply of drugs for inpatients shall be based upon doctor original prescription . No transcription of prescription is allowed.

6.15 HOTEL SERVICES POLICIES

6.15.1 POLICIES

6.15.1.1 The Hospital Management shall be responsible to provide hotel-like services to the patient consisting of Catering Services, Laundry Services and Housekeeping Services .

6.15.2 PROCEDURES FOR CATERING SERVICES

6.15.2.1 Food for second and third class patients shall be transported in specific food trolleys and plated in the ward pantry except for certain wards which will be plated individually as budget permits .

6.15.2.2 Food for first class patients shall be transported in specific food trolleys and plated in the Department of Dietetics and Food Services itself. The food trays shall be wrapped and covered individually.

6.15.2.3 All used plates, cutlery and food containers shall be washed in the ward pantry and all food containers shall be returned to the Department of Dietetics and Food Services after washing.

6.15.2.4 All patients shall be supplied with four meals a day . Dietary guidelines produced by the Ministry of Health shall be complied with.

6.15.2.5 Hospitals staff shall take meals in specified rooms only e.g. staff rest room . These rooms shall be kept clean of leftovers at all times as a measure of pest control .

6.15.2.6 Certain staff shall be provided with food from the kitchen (e.g. meals for Doctors On-Call and Night Rations for staff on Night Shift and Operation Theatre who work through lunch time) .

6.16 PROCEDURES FOR LAUNDRY SERVICES

6.16.1 The Laundry services shall be managed by the private consortium.

6.16.2 The Laundry shall exchange and replace the linen supplied to the wards and units on a regular basis

6.16.3 Soiled linen from the wards and units shall be collected from the wards / units and sent to the Laundry daily .

6.16.4 Soiled linen in used CSSU packs shall be collected from the wards / units and sent to the laundry .

6.16.5 A minimum of three sets of patient's linen per bed excluding stock shall be available at any time except for blankets & mosquito nets which shall be made available in adequate numbers .

6.16.6 Patients must be allowed to use their own clothes except for infectious cases .

6.17 PROCEDURES FOR DOMESTIC SERVICES (HOUSEKEEPING)

6.17.1 General cleaning of department shall be done by the private consortium . Cleaning shall be according to the Hospital Specific . Implementation Plan (HSIP) and the Technical Requirements and Performance Indicators (TPRI).

6.17.2 The assistant administrator shall supervise the overall cleanliness of the place. However individual departmental / unit heads shall be responsible for supervising the cleanliness of their respective department / units .

6.18 SECURITY

6.18.1 POLICIES

6.18.1.1 The Hospital Management shall be responsible to provide optimum security of the facilities , patient and staff in accordance to "Arahan Keselamatan dan Garispanduan Sistem Kawalan Keselamatan Hospital Sultanah Aminah Johor Bahru "

6.18.2 PROCEDURES

6.18.2.1 Visitors control in the hospital walkway, lifts and all entrances shall be maintained.

6.18.2.2 The Hospital Management shall provide a Security Counter at every main entrance, the hospital lobby, and all passenger and staff lifts.

6.18.2.3 All patients admitted into the wards should agree not to bring their valuables and cash money in large amounts for security reasons .

6.18.2.4 Patients shall be advised to hand over their valuable items to their next-of-kin for safe keeping.If the patient came without relatives valuables and money shall be kept in the ward safety box if available or handed over to the Hospital Management staff for safe keeping. The procedures to be followed is provided in guidelines by the Ministry of Health .

6.18.2.5 To ensure safety of newborn, Identification (ID) Bands with identical numbers shall be placed on mother and baby immediately following birth in the Labour Room or Operation Theatre. These ID Bands shall not be removed before discharge. The nurse in charge shall advise mother to never leave baby alone or unsupervised in the ward. ID Bands will be checked each time baby is brought to mother from the nursery.
ID Bands will be checked by nurse in charge on discharge from ward.
ID Bands will be checked again at main exit gate of *Bangunan Induk*. ID Band shall be removed by mother at home.

6.18.2.6 Cash collected at all counters e.g. Specialist Clinics , Pathology Unit , Emergency Department , etc , shall be stored in a money box which shall be kept in a locked drawer at the reception counter. It shall be transferred to the main safe in the Administration Unit half an hour before the end of each day .

6.18.2.7 A master key system shall be in operation . All entrance keys shall be kept at the telephone operator's room after office hours . Staff shall sign in the record book provided when taking and returning keys. Only authorized staff are allowed to take the entrance keys .

6.18.2.8 Controlled drugs shall be in the controlled drugs cupboard .

6.18.2.9 Certain areas shall have special security precaution : Medical Records , Maternity , SCN , Medical Store , ICU , Paediatric Ward , IT Unit and Bilik Kualiti.

6.18.2.10 Use of hand phone and remote control equipment is prohibited in specific areas e.g. A&E , ICU , HDW , SCN , OT , Labour Room and wards .

6.18.2.11 Smoking is prohibited within the Hospital Compound .

6.18.2.12 Staff shall be responsible to ensure the safety and security of government assets , inventories and documents .

6.18.2.13 Regular site patrols shall be undertaken by security guards .

6.19 MEDICAL RECORDS

6.19.1 POLICIES

6.19.1.1 The Hospital Management shall be responsible to maintain delivery , storage and retrieval of records and reports in accordance to Ministry of Health Guidelines as well as other regulations in force

6.19.1.2 All requests for medical reports shall go through the main revenue counter .

6.19.1.3 All the hospital's data shall be accumulated at the Statistic Unit and shall be provided to the Hospital Management when necessary.

6.19.2 PROCEDURES

6.19.2.1 Discharge summary shall be done within 3 days after patient's discharge.

6.19.2.2 The medical record department shall be responsible for all inpatient records including X-ray films

6.19.2.3 Specialist Clinics shall hold their own records. Active records shall be held at the reception counter of the department . Passive

records up to 7 years shall be held at the supplementary stores.

6.19.2.4 Emergency Department records shall be sent to the Medical Record Department the following day for trauma cases and shall be held by the department for non trauma cases.

6.19.2.5 All patient's medical records shall be dispatched to and from the Medical Records Unit in the security bags provided .

6.19.2.6 All patients' medical records shall be held by the hospital for a period of 7 years from the time it was last activated except for records from psychiatry which will be held for a period of 3 years after the patient has died and for obstetric and paediatric patients' shall be held for 21 years.

6.19.2.7 Patients shall not be allowed to carry or take their own medical records.

6.19.2.8 Medical records shall be dispatched within the hospital by authorized personnel only. Transportation outside the hospital is strictly forbidden, except under suppoena or court order.

6.19.2.9 All inpatient's record shall be dispatched to the medical record unit within 3 working days after patient has been discharged.

6.19.2.10 To facilitate control, wards should send all patients' record to the medical record department. If the record is required by the medical officer or clinic it should be traced at the medical record department.

6.19.2.11 Outside of the medical record department, the safety of medical records shall be the responsibility of the staff of the respective clinic/ward/ department.

6.19.2.12 Copies of medical records made in any form is prohibited except with the permission of the Hospital Director or a court order.

6.19.2.13 Information about the patient shall only be released with the consent of the patient or the guardian if the patient is underage or unfit , or the next-of-kin if the patient has died. However , information should not be released without the prior knowledge and approval of the Hospital Director .

6.19.2.14 Medical reports shall be requested by patient's themselves , patient's lawyers or the police or Head of Government Departments .

6.19.2.15 The payment for medical reports is set out in the Medical Fee Ordinance 1982

6.19.2.16 Daily Ward census shall be sent to the Statistic unit the following day (working day) after data capture at mid night

6.19.2.17 Outpatient's data shall be sent before the 7th of every month to be accumulated at the Statistic Unit

6.20 ENGINEERING

6.20.1 MAINTENANCE POLICIES

6.20.1.1 Maintenance of facilities engineering and bio medical engineering is privatized to the Concession Company .

6.20.2 PROCEDURES

6.20.2.1 All departments shall request for repairs by telephoning the private consortium's service centre , obtaining the Requisition number and stating the nature and location of the repairs required .

6.20.2.2 The private consortiums shall be responsible for carrying out the daily and weekly maintenance according to procedures recommended by the manufacturers.

6.20.2.3 Regular maintenance of facilities , technical electrical and medical equipment shall be undertaken by the private consortium in accordance to a Concession Agreement , Hospital Specific Implementation Plan (HSIP) and Technical Requirements and Performance Indicators (TPRI)

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

6.20.2.5 All departments / units shall maintain an update inventory of all equipment and assets in the departments / units . The departments / units head shall ensure that these equipments are serviced regularly and maintained by the private consortium .

6.20.2.6 All equipment considered not functional or beyond economic repair shall be disposed off in accordance to the " Garispanduan Pelupusan " of the Ministry of Health .

6.21 SAFETY AND HEALTH

6.21.1 POLICIES

6.21.1.1 The Hospital shall have a Safety and Health Policy. The Occupational Safety and Health Committee shall implement , monitor and evaluate all safety aspects related to staff , physical , chemical , mechanical and environment , etc. in accordance to Occupational Safety and Health Act .

6.21.2 PROCEDURES

6.21.2.1 Procedure in implementation of Safety and Health Policy , Safety and Health activities is documented in Safety and Health Manual for Hospital Sultanah Aminah Johor Bahru

6.22 FACILITIES AND EQUIPMENT

6.22.1 COMMUNICATION SYSTEM

6.22.1.1 POLICIES

6.22.1.1 The Hospital Management shall be responsible to install and maintain the communication system such as telephone , nurses call bell , pager , hand phone and two way radio communication (walkie- talkie) for ambulances in the Hospital . The Ambulance Call Centre is responsible to coordinate Ambulance Calls and Emergency Ambulance Services within the district upon request by the public .

6.22.1.2 The Hospital Management shall be responsible to provide facilities for Continuing Medical Education for staff , trainee doctors and post-graduate doctors .

6.22.2 PROCEDURES

6.22.2.1 Telephones

- Direct dialing to selected MOH Hospitals throughout the country shall be made available Direct dialling within the hospital shall be made available.
- Telephones/Fax are restricted for official use only unless authorized otherwise .

6.22.2.2 Nurse Call System

6.22.2.3 Hand Phone

- The guidelines of the Ministry of Health on the hand phone system shall be complied with .

6.22.2.4 Emergency and Trauma Department (ETD)
Call Centre

- The ETD Call Centre will receive emergency calls from police , public etc and is responsible to dispatch ambulance as soon as possible.

- To send Emergency Ambulance Service within Hospital coverage area or to inform the Medical Assistant on call to respond with Emergency Ambulance Service from nearby Health Clinic to the scene. However , in case of no ambulance available at that particular Health Clinic , the nearest neighbouring Health Clinic or Emergency Department has to send Ambulance and staff to the scene immediately .

6.23 STAFF WELFARE

6.23.1 POLICIES

6.23.1.1 The Hospital Management shall have documented policies and procedures to provide for staff welfare in order to promote healthy work-force and healthy workplace

6.23.2 PROCEDURES

6.23.2.1 Priority in allocating hospital quarters shall be given to staff who are on-call .

6.23.2.2 Space for recreational facilities , both indoor and outdoors , may be made available subject to availability of space for staff

6.23.2.3 Staff shall be encouraged to establish a social , sports and welfare society to promote goodwill and establish closer ties among staff .

6.23.2.4 Staff rest rooms and prayer (solat) for Muslim staff shall be provided .

6.23.2.5 Lockers shall be provided for staff use in specific areas .

6.23.2.6 A public canteen / cafeteria shall be provided in which a special section may be reserved for staff use subject to availability of space.

6.24 ACCESS AND PARKING

6.24.1 POLICIES

6.24.1.1 The Hospital Management shall provide access to parking, subject to availability to the staff and patients. Parking within Hospital premises is "At Own Risk"

6.24.2 PROCEDURES

6.24.2.1 The Emergency Department and the clinics shall not be used as the main thoroughfare for entering the hospital

6.24.2.2 Public transport vehicles are allowed to enter the hospital grounds only at the designated points.

6.24.2.3 All staff shall park at the designated staff car park areas .

6.24.2.4 No parking is allowed at the Emergency Department and the main entrance porch.

6.24.2.5 All hospital vehicles other than ambulance and staff saloon cars shall park at the rear of the service centre .

6.24.2.6 Students from Monash University and other Universities or other institutions shall park their vehicle at the public parking area .

6.24.2.7 All vehicles sending patients to the hospital shall park at the visitor's car park immediately after dropping off the patient .

6.25 HOSPITAL BOARD OF VISITORS

6.25.1 POLICIES

6.25.1.1 The Hospital shall have a board of visitors with 9 to 18 members , whom are appointed for a period of 2 or 3 years .

6.25.1.2 The Board of Visitors (BOV) shall function in accordance to the Ministry of Health's guidelines .

6.25.2 PROCEDURES

6.25.2.1 Identifications passes shall be issued to members of the BOV for use during visits to the hospital .

6.25.2.2 The board shall be accompanied by a designated staff / sister on morning duty during their visits . The board shall not visit restricted areas such as the operating theatre , delivery suite , CSSD , isolation rooms ,medical store , etc.

6.25.2.3 Visits and meetings shall be held regularly (but not less than once in 3 months.) Reports of visits and minutes of meeting shall be kept in the office , and copies forwarded to the State Director's office .

6.25.2.4 The BOV may obtain information from patients regarding hospital facilities, food, clothings , cleanliness and services provided by the staff , but shall not discuss with patients the technicalities of the treatment provided nor examine the patients' case notes .

6.25.2.5 The BOV shall act as a link between the hospital and the public and contribute in various ways to the hospital's program such as hospital image , welfare program , etc.

6.26 PUBLIC RELATIONS

6.26.1 POLICIES

6.26.1.1 Generally , it shall be the policy of the hospital to provide a public relations organizational set-up with the following objectives :

Θ to monitor and improve on the hospital's relations with those members of the public such as patients, visitors or others who have contact with the hospital :

Θ to maintain internal public relations so as to improve on staff information and esprit de corps and project a corporate identity .

Θ to co-ordinate the hospital's relations with the public through the new media .

6.26.2 PROCEDURES

6.26.2.1 Release Of Information

- For ethical and legal reasons , all staff of the hospital shall respect the confidentiality of information , acquired either directly or indirectly, relating to any patient, his or her immediate condition, diagnosis and treatment
- Only the hospital director or his representative is authorized to give statements to the press .
- As the release of information on patient may have serious implications , any member of the staff who does not comply with this policy shall be subject to disciplinary action

6.26.2.2 Photography / Filming / Interviews

- No photographing , filming , etc shall be carried out within the premises of the hospital without the prior permission of the hospital director .
- Permission for the privilege of photographing a patient in a hospital may be given if :
- In the opinion of the doctor in charge of the case , the patient's condition will not be jeopardized
- The patient's (or in the case of a minor , the parent or guardian) approval
- Interview of the patient shall not be allowed if he (or his parent or guardian) objects or in the opinion of the attending doctor , his condition does not permit it .

6.27 TRAINING AND ATTACHMENT PROGRAMME

6.27.1 POLICIES

6.27.1.1 This hospital is recognized as a training hospital by Ministry of Health for the training of under and post graduate medical and non medical students, house officers, junior doctors , Allied Health housemen and medical and paramedic students from medical and non medical institutions .

6.27.1.2 Students are allowed to do their attachment posting in the hospital in accordance with Ministry of Health Guidelines.

6.27.1.3 The Hospital Management shall have a Memorandum Of Understanding (MOU) from universities / institutions for placement of students and appoint local preceptors .

6.27.2 PROCEDURES

6.27.2.1 Permission shall be granted from Ministry of Health, State Health Department or at the Hospital level.

6.27.2.2 Student(s) shall be introduced and posted to the respective department(s) as stated in the request letter from the universities / institutions

6.27.2.3 Student(s) shall report to Hospital Director or his/her representative or Head of Dept/Unit on the first day of their attachment to this Hospital

6.27.2.4 The student (s) shall abide to the existing policies, procedures and work ethics of the Ministry of Health and Hospital Sultanah Aminah Johor Bahru .

6.28 HOSPITAL VOLUNTARY SERVICE

6.28.1 POLICIES

6.28.1.1 The Hospital Management shall be responsible to coordinate, monitor and evaluate the performance of the Hospital Voluntary Service and the volunteers.

6.28.2 PROCEDURES

6.28.2.1 The Hospital Volunteers shall be appointed by the Ministry of Health and given identification cards produced by the Ministry of Health.

6.28.2.2 The Hospital Volunteers shall abide by the existing policies , procedures and work ethics of the Ministry of Health and Hospital Sultanah Aminah Johor Bahru.

6.29 QUALITY IMPROVEMENT ACTIVITIES

6.29.1 POLICIES

6.29.1.1 The Hospital shall have documented quality policies and ensure the establishment and maintenance of an effective quality improvement program throughout the facility.

6.29.1.2 The Hospital shall have a committee to look at the overall responsibility to ensure the development, implementation, monitoring and evaluation of the Quality Assurance Program which provides a systematic review of the quality and effectiveness of services rendered.

6.29.2 PROCEDURES

6.29.2.1 All staff shall be made familiar with the Quality Assurance Programme to adopt and practice quality at all times.

6.29.2.2 The Hospital Director shall conduct Quality Steering Committee / Quality Assurance meetings on a regular basis. Quality Assurance shall be made a permanent agenda in all management meetings.

6.29.2.3 All departments shall carry out management and medical audit as well as studies and research activities as a process to review and evaluate the following services:

- Clinical
- Nursing
- Clinical Support
- Medical Records
- Other Support Services.

6.29.2.4 Other appropriate review methods and procedures shall be in place to ensure that patient care resources are utilized effectively and efficiently.

6.30 PAIN ASSESMENT AND MANAGEMENT.

6.30.1 POLICIES

6.30.1 Pain is assessed in all patients.

6.30.2 Pain is one of the Vital Signs.

6.30.3 Standardized pain assessment tools must be applied consistently.

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

6.30.5 Healthcare facility staff should be continually educated and aware about pain assessment and management.

6.31 PRACTICE OF MINIMALLY INVASIVE SURGERY (MIS)

6.31.1 POLICIES

6.31.1.1 All Surgical Departments should ensure that MIS technique are encouraged to be used for established MIS surgical procedures.

6.31.1.2 Patients are encouraged to opt for minimally invasive surgical techniques and are appropriately advised the benefits of MIS.

6.31.1.3 The patients should be appropriately counselled, and consent is obtained correctly.

6.31.1.4 Conversely, the patient should be advised appropriately against MIS if such a technique is unsuitable for a particular procedure or during certain circumstances.

6.32 ENERGY MANAGEMENT POLICY

6.32.1 POLICIES

6.32.1.1 Hospital Sultanah Aminah is committed to supporting, emphasizing and practicing energy management and conservation initiatives in line with Efficient Management of Electrical Energy Regulation 2008 and other related regulations.

6.32.1.2 This is to create a sustainable energy management system to:

- Promote efficient energy management for continuous savings.
- Encourage the reduction of carbon dioxide gas production.
- Encourage innovation in green technology.
- Implement Government Green Procurement (GGP).
- Provide the necessary resources to achieve objectives and efficiency targets energy.

6.32.2 PROCEDURES

6.32.2.1 The energy management committee shall implement the energy policy for performance improvement and express management's commitment to energy efficiency.

6.32.2.2 It is duty of EMC to educate all employees and concession company to practices energy efficiency and its environmental impact

6.32.2.3 It is secretary duty to post the policy in prominent location as a visual reminder to all.

6.32.2.4 It is EMC responsible to communicate the energy policy to all employee and concession company

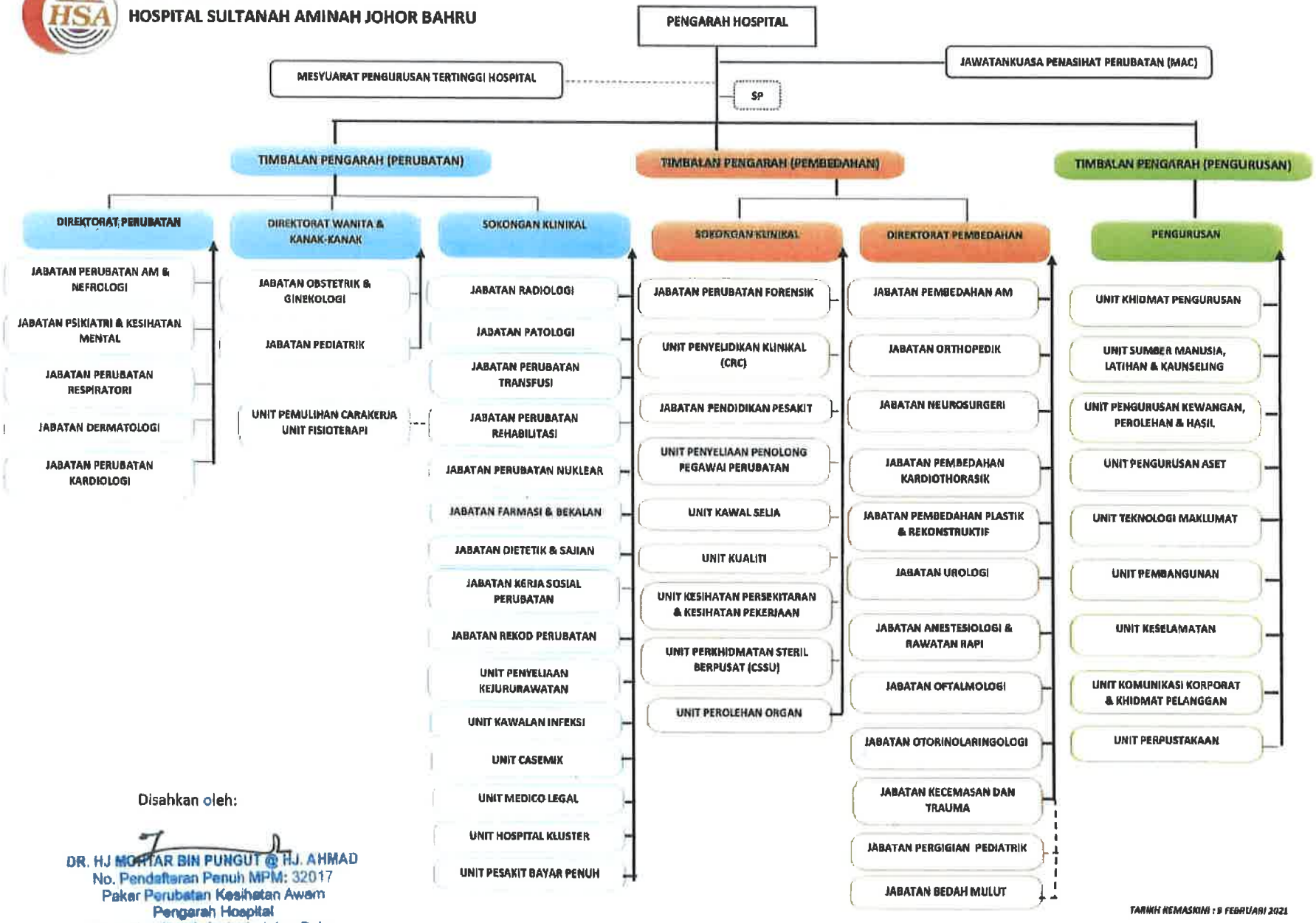
6.32.2.5 The management is committed to allocate sufficient resources to support energy management activities.

6.32.2.6 It is duty of secretary to report at least twice in a year on energy use to energy management committee (EMC).

6.32.2.7 It is Hospital's duty to ensure that new equipment and building projects are energy efficient type which in line with Government Green Procurement (GGP).

6.32.2.8 Energy Policy shall be review at least once in 2 years as per necessary

CARTA ORGANISASI
HOSPITAL SULTANAH AMINAH JOHOR BAHRU



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