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<th>PENULIS DOKUMEN : (DOCUMENT'S WRITER)</th>
<th>ASSOC. PROF. DR. MOHD IDZWAN BIN ZAKARIA DR. RUSINAHAYATI BT MOKHTARUDIN MARIASHABIRADALIA BT MOHD HASHIM MARIAM BT MOHD NASIR NURHAYATI BT MOHD NUR</th>
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DOKUMEN INI ADALAH HAK MILIK SEPENUHNYA PUSAT PERUBATAN UNIVERSITI MALAYA (PPUM). SEBARANG SALINAN SEBAHAGIAN ATAU SELURUHNYA DOKUMEN INI TIDAK DIBENARKAN SAMA SEKALI KECUALI MENDAPAT KEBENARAN SECARA BERTULIS DARI BAHAGIAN PENGURUSAN KUALITI, JABATAN KUALITI, PUSAT PERUBATAN UNIVERSITI MALAYA. THIS DOCUMENT BELONGS TO UNIVERSITY MALAYA MEDICAL CENTRE (UMMC). ANY DUPLICATION PARTIALLY OR FULLY IS PROHIBITED EXCEPT WITH WRITTEN CONSENT FROM QUALITY MANAGEMENT DIVISION, QUALITY DEPARTMENT, UNIVERSITY MALAYA MEDICAL CENTRE.
### A. ADMISSION AND DISCHARGE

#### A1 Activity Level Requirements:

1. **1.1 Authorized Staff**

   Appointed and authorized UMMC medical practitioners of a specialty are allowed to admit patients to their specialty. All medical practitioners with authority to admit patients shall be governed by the official admitting policy of the Hospital.

2. **1.2 Patient assessment**

   All patients shall be assessed according to [PL-009 Assessment of Patients Policy](#) before a decision for admission is made at:
   - Outpatient Specialty Clinics
   - Primary Care Clinic (RUKA)
   - Daycare
   - Trauma & Emergency Department
   - General Admission counter for elective
   - Admission counter to the labour delivery suites
   - Direct admission for special cases according to [PL-005 Patient Admission/Receiving Policy and Procedures](#)

3. **1.3 Reason for admission**

   The reasons for admission according to priority are:
   
   a. Emergency/Urgent
   b. Elective such as pre-operative; or routine assessment/evaluation.

   Admission decision and priority is based upon availability of resources and clinical decision/judgment made by the attending medical practitioners. Bed Manager shall be given authority to coordinate bed allocation for patients and shall work closely with consultant in charge the ward in bed management. Admission will depend on the availability of vacant beds. Where there is no vacant beds, admission will only be made when the consultant in charge the ward or Head of Department makes room for the new patient by discharging others in his department. It will be the responsibility of the consultant in charge and bed manager to keep a certain number of beds vacant for emergency cases.

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**Tarikh Berkuatkuasa: (Effective Date)**

| 04-11-14 |

**No. Kajisemula (Revision No.)**

| R00 |
A2. Responsibility for Care of Hospital Patients:

a. The primary team who admit the patient shall be responsible for the overall medical care of each patient in the Hospital until discharge or transfer to other hospital or other specialty. The attending practitioner shall be responsible for the treatment and the prompt completeness and accuracy of the medical record, for necessary instructions and for transmitting reports of the condition of the patient, if appropriate; the responsibility towards the patient can be transferred to the referring practitioner within the Department.

b. Such transfer of responsibilities shall be made with the approval of the receiving practitioner. When responsibilities are transferred to another practitioner, such transfer documentation should be reflected in the medical record.

c. Inter-hospital transfer shall be done at consultant level including accepting admission from other hospital. The referring consultant shall communicate with receiving consultant via phone or letter.

d. The patient shall be admitted to the ward of the service concerned in the treatment of the disease that necessitated admission. The Medical practitioner in charge shall be responsible for supervising House officers in the provision of care to patients under their care.

e. Referral to other Department

   The attending practitioner shall refer the patients to other specialty if necessary. In ward or intra-operative referral must be at specialist level. The attending specialist shall communicate with the receiving specialist via referral form and/or a phone call and documented in the clinical notes.

A3. Medical Practitioner Coverage Arrangements

Head of Department shall ensure the coverage of patient care if the medical practitioners are not available including during on call duty. This arrangement shall be made known to the Hospital telephone operators, consultant on call on that specialty and consultant/specialist in charge Trauma and Emergency Department. Failure of practitioners to meet these requirements may result in disciplinary action.

Medical Practitioners on active call duty, after usual office hours, will be required to sleep in the duty rooms provided in the Hospital. Medical Practitioners on passive call shall be contactable for 24 hours and able to report duty to the hospital as soon as possible when required. All “on duty” and “on call” rosters whether pertaining to medical staff must be exhibited on the notice boards in each Department/Unit and required number of copies lodged with the Director/Deputy Director Professional and hospital operators. Any changes made in the rosters must receive the official sanction.
of the Head of the Department and copy of such changes to be given the Director/Deputy Director Professional.

A4. **Provisional Diagnosis/Reason for Admission**

Except in the case of emergency admissions, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated and documented. In the case of an emergency such statement shall be recorded as soon as possible. A copy of complete emergency service record shall accompany the patient to the ward.

A5. **Emergency Admissions**

Practitioners shall be able to justify emergency admissions based on criteria in the admission policy. The history and physical must clearly justify the patient being admitted on an emergency basis and these findings must be recorded on the patient's medical record as soon as possible after admission. Admission Order of Priorities - Patients shall be admitted to the Hospital on the basis of the following order of priorities when there is a shortage of available beds:
1. Emergency-life threatening condition
2. Urgency-condition requiring close observation and in patient treatment

Violators of this rule shall be referred to the Medical Advisory Committee for appropriate action.

A6. **Transfer of Patients**

Patients with conditions whose definitive care is beyond the capabilities of this Hospital resources shall be referred to the appropriate facility when, in the judgment of the attending practitioner, the patient's condition permits such a transfer and according to PL-006 Patient Transfers Policy and Procedures.

A7. **Compliance with Utilization and Resource Management Plan**

Practitioners shall abide by the Hospital's Utilization and Resource Management plan to include:
- Severity of illness and intensity of services;
- Continued requirement of acute or transitional care services;
- Efficient use of supportive services; and
- Timely discharge planning.

A8. **Time of Discharge**

Whenever possible, practitioners shall prepared pre-discharge summary and discharge order that will allow patients to be discharged from the Hospital by 11:30 am for morning ward round or before 6.00pm for afternoon ward round. The consultant/specialist in charge the ward is overall responsible on the
completeness and verification of the discharge summary before given to the patient in timely manner.

If a patient leaves the Hospital against the advice of the attending practitioner, or without proper discharge, a notation shall be made in the patient’s medical record and the patient should be requested to sign the Hospital’s “leaving hospital against medical advice” after given adequate professional advice and option to the patient. Such communication shall be documented in the patient’s medical notes. The responsibility of the decision on discharge against medical advice shall be at specialist level. Such patient is considered under hospital care and responsibility as long as patient physically still in the ward and shall receive appropriate treatment whatever possible until the patient physically discharged.

A9. Pronouncement of Death

In the event of any death, the deceased shall be pronounced dead by the attending physician within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the deceased by the attending physician. The Burial permit and Medical Cause of Death Certificate shall be filled and signed by fully registered medical practitioners. Policies and procedure management of death of patient in the hospital including release of dead bodies shall be followed.

B. EMERGENCY SERVICES

B1. Emergency Service Call Responsibility

All appointed UMMC Medical Practitioners shall accept responsibility for Emergency Department call coverage and care, be immediately available to the hospital and Emergency Department when needed, and assure follow-up care within the standards of care in accordance with applicable policy and procedures. Delineation of Clinical Privileges: Practitioners Rendering Emergency Care - Clinical privileges shall be delineated for all practitioners rendering emergency care in accordance with PL-046 Credentialing and Privileging Policy For Medical Practitioner and Allied Health Staff. Treatment and procedures shall be provided within those areas of competence indicated by the scope of the practitioner’s delineated clinical privileges.

B2. Responsibility for Emergency Care

The Head of the Emergency Department has oversight responsibility of the quality of care within the Emergency Department. The Emergency Department will review quality reports on a regular basis.

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B3. Emergency Department Coverage

a. Primary coverage schedules are prepared and posted in the Emergency Department.
b. Specialty call schedules are posted in the Emergency Department.

B4. Availability of Emergency Services Physician

An emergency services physician shall be in the Hospital and immediately available for rendering emergency patient care 24 hours per day, seven (7) days per week.

B5. Clinical Care at Trauma and Emergency

The overall clinical management and coverage shall be in accordance with PL-012 Trauma and Emergency Operational Policy. Immediate resuscitation and emergency treatment shall be given in the Department prior to admission to the wards. Those not requiring admission will be treated as outpatients. The Trauma ward is provided for observation of patients for not more than 24 hours and for admitted patient waiting for bed in the condition of bed constraints.

B6. Admission of Emergency Department Patient

If a patient needs to be admitted to the Hospital as an inpatient, in the judgment of the emergency physician either for observation or for further treatment, the patient shall be admitted in the name of the practitioner on-call/admitting physician with the consent of that practitioner/admitting physician and within the guidelines maintained in the Emergency Department, the emergency physician shall write admission orders with the following stipulations:

1. Emergency physician admission orders shall be considered to be temporary holding orders written with the purpose of expediting the movement of admitted patients from the Emergency Department to the ward.
2. Emergency physicians will write admission orders only after the patient has been accepted by the admitting physician (specialist) and with that physician's consent.
3. All admitted patients will become the responsibility of the admitting physician as soon as the admitting physician has been contacted by the emergency physician and the admitting physician has accepted the patient for admission to his/her service.
4. The admitting physician will be notified of the patient's arrival in the ward and the orders will be verified by the admitting physician. He/she will be asked to accept or revise the orders at that time.

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a. If, in the judgment of the emergency physician, the patient's condition requires continuing practitioner attendance the emergency physician shall continue to accept responsibility for the patient until the assigned practitioner assumes responsibility for the patient by physically coming to the Emergency Department and caring for the patient. The assigned practitioner shall respond to the call within five (5) minutes, and come to the Emergency Department as soon as appropriate for the clinical condition of the patient, if requested by the emergency physician.

b. If, in the judgment of the emergency physician consultation is required, the requested physician must respond: (1) within ten (10) minutes of being called in cases of emergency; or (2) within thirty (30) minutes of being called for non-emergent cases, and come to the Emergency Department as soon as appropriate for the clinical condition of the patient, if requested by the Emergency Services Physician.

(5) In cases of severe sepsis, where the decision is not being made within one hour of clinical management, the Emergency physicians will appoint a responsible primary team. All severe sepsis or septic shock patients need to be notified to the emergency physicians on duty by the emergency medicine medical officers.

a. Emergency physician needs to inform the primary team specialist on the appointment and document in the notes.

b. ICU team has to be notified as soon as possible if the patient is in severe sepsis or septic shock requiring admission to ICU. If crash/code blue doctor cannot be contacted via a dedicated hand-phone number, the emergency department (ED) can call the ICU ward directly for the referral.

c. The appointed primary team is responsible for the patient care unless/until the diagnosis changes. It is the responsibility of the appointed primary team to make the appropriate referral to the new primary team. This process can occur as the patient is being stabilized and resuscitated in ED or ICU. During this critical period, the primary goal of ED or ICU doctor would be to resuscitate and stabilize the patient as in the guidelines Surviving Sepsis Campaign Guidelines: International Guidelines for Management of Severe Sepsis and Septic Shock 2012 and transfer the patient to a critical care area in ICU or ward High Dependency Unit without delay from issue of whom should be the primary team.

d. The case should then be sent to ICU and if there is no ICU bed available, the patient will be sent to the ward HDU of the primary team, these processes should occur fast, without delay.
B7. **Performance of Surgery in the Emergency Department**

Except in cases where transfer to surgery is contraindicated in the judgment of the emergency physician, surgery shall not be performed in the emergency treatment area.

B8. **Emergency Department Medical Record**

An appropriate emergency service medical record shall be kept for every patient receiving emergency service and shall be incorporated in the patient's previous inpatient medical record, if such exists. The emergency service medical record shall include:

a. Adequate patient identification;
b. Information concerning the time of the patient's arrival and by whom transported;
c. Pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to his/her arrival at the Hospital and history of allergies;
d. Description of significant clinical, laboratory and X-ray findings;
e. Diagnosis including condition of patient;
f. Treatment given and plans for management;
g. Condition of the patient on discharge or transfer; and
h. Final disposition, including instruction given to the patient and/or his/her family, relative to necessary follow-up care. Signing of Emergency Medical Record - Each patient's emergency medical record shall be signed by the practitioner in attendance who is responsible for its clinical accuracy.

B9. **Review of Emergency Department Records**

The Emergency Department Head or shall coordinate the review of emergency service records and report results to the Medical Record committee.

B10. **Responsibility for Studies**

The Emergency Department Head or the Emergency Service Committee shall be responsible for studies concerning the quality and appropriateness of patient care.

B11. **Medical Record Upon Admission**

The emergency service medical record shall accompany patients being admitted as an inpatient.
B12. Disaster Plan

The Emergency Department Head shall make certain that emergency service procedures are properly coordinated with the DS0799 Guidelines on Disaster Plan, especially as they pertain to the care of mass casualties.

C. HEALTH INFORMATION MANAGEMENT SYSTEM

C1. Responsibility for Preparation of Complete, Legible Medical Record –

The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current for each patient. This record shall include identification data; chief complaint; medical history; history of present illness; physical examination; diagnostic and therapeutic orders; appropriate informed consent(s); clinical observations including results of therapy, progress notes, consultations and nursing notes; reports of procedures, tests and results including operative reports; conclusions at termination of hospitalization to include relevant diagnoses and clinical resume; and autopsy report when performed.

a. Clinical notes documentation shall be written by all Medical Practitioners attending the patients, or such entries can be written by other Practitioners who attending the patients at the same time.

b. Medical Assistants, Registered Nurses, Certified Nurse Midwives and other Allied Health Staff may write orders in the clinical notes within the scope of their list of approved privileges given

C2. Recording History and Physical - A complete admission history and physical examination shall be done within 30 minutes of inpatient admission and documented. Additionally, an appropriate medical history and physical examination shall be recorded on all patients undergoing outpatient surgery/procedure and observation at the time of the visit. This report should include all pertinent findings resulting from an assessment of appropriate systems of the body.

C3. Completion of Medical Record - A medical record shall not be filed until it is completed by the responsible medical practitioner or is ordered filed by the Medical Record Committee.

C4. Operative Reports - Operative reports shall include a detailed account of the finding at surgery as well as the details of the surgical technique. Operative reports shall be recorded immediately following surgery when possible for all patients and the report authenticated by the surgeon and made a part of the patient's current medical record, as soon as possible after surgery.

C5. Clinical Entries in the Medical Record - All clinical entries in the patient's medical record shall be dated, timed, and authenticated by written signature,
C6. All orders for treatment shall be in writing and signed with name in block letter/official stamping by the medical practitioner and allied health staff with such privileges, or the House officers responsible for the patient. **Signature stamps are prohibited.**

Entries in the medical record by House officers that require countersigning by supervisory or attending practitioners include: operative reports, procedure notes, discharge summaries, pre-anesthesia record, anesthesia record, post-anesthesia note, pre-operative note, post-operative order.

C7. Verbal communication of medication orders and test results shall be permitted for urgent situations only, in which immediate written or electronic communication is not feasible. Orders dictated over the telephone shall be signed by the appropriate authorized person according to PL-029 Verbal Communication Policy, whom dictated and indicating the name of the Practitioner who gave the order. The Practitioner giving the order shall authenticate such verbal orders within twenty four (24) hours.

C8. Symbols and Abbreviations - The hospital maintains a list of abbreviations, acronyms, and symbols that are acceptable in patient medical records applicable to all orders and other medication-related documentation when handwritten, entered as free text into a computer, or on pre-printed forms, consistent with the PL-033 Medical Record Policy.

C9. Discharge Summaries - A discharge summary shall be written for all patients hospitalized including patients who admitted at Trauma ward except patient categorized as for observation only. All summaries shall be authenticated by the responsible practitioner (Senior Medical Officer or specialist) and given a copy to patient upon discharge except for Psychiatric case. In the event of death, a summary statement shall be added to the record and procedure of management of death shall be followed.

C10. Consent of Patient - Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive the information.

C11. Readmission of Patient - In case of readmission of a patient, the previous record shall be available upon request for use by the attending practitioner.

C12. Access to Medical Records - Access to medical records of patients will be afforded to members of the Staff and former members of the Staff to the extent permitted by law or by legally effective patient consents.
C13. Obtaining Informed Consent - Practitioners shall obtain and document the patient's informed consent including risks, benefits, and alternatives. When consent is not obtainable, the reason shall be entered in the patient's medical record. The medical record shall contain evidence of informed consent for procedures and treatments for which it is required by hospital consent policy. The practitioner shall document that informed consent has been obtained and that the patient understood and agreed to the proposed treatment.

C14. Surgical/Invasive Procedure Consent - Written, signed, informed surgical consent shall be obtained prior to the operative procedure except in extreme situations wherein the patient's life is in jeopardy and suitable signature cannot be obtained due to the condition of the patient. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be obtained from the patient, guardian or responsible family member, these circumstances should be fully explained on the patient's record. A consultation and agreement from two consultants shall be done in such instances before the emergency operative procedure if time permits. The practitioners shall comply with PL-040 Consent Policy.

C15. Countersigning Responsibilities - The attending practitioner shall read, edit and review the history and physical examination, pre-operative notes, and discharge summaries when they have been recorded by house officer, if changes are made on review the attending physician will sign and date the changes.

C16. Timely Completion of Medical Records - The attending practitioner shall complete the medical record, to include progress notes, final diagnoses, discharge summary and all required signatures and official stamping, following the patient's discharge within 3 days before sending it to Medical Record office. The consultant in charge of the primary team shall be the responsible on the completeness of the Medical records. A House officers shall be required to utilize annual leave until all delinquent medical records are completed.

C17. Timely Completion of Medical Reports- The attending practitioner shall complete the medical report within 30 days upon request and notification by Medical Record Office. If the practitioner, for some reason, is unable to meet the 30 days deadline, shall convey the reasons to the Medical Record officer in writing who will inform the applicant about the delay and set a new early deadline not later than 14 days. It is unethical for practitioner to refuse to provide a medical report and the patient has a right to complain to Malaysian Medical Council of any such refusal or undue delay. The Head of the department shall be the responsible on the completeness of the Medical report on time.

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C18. Incomplete Medical Records and Reports : Delinquency - The Head of Medical Record Department will maintain a continuous listing of all incomplete records and reports and their corresponding delinquency status. Practitioners will be individually notified in writing of the status of all incomplete records or reports, to include total number of charts and type of deficiency and are required to complete it within thirty (30) days upon notification.

On an as-needed basis, the Head of Medical Record will provide to the Medical Advisory Committee a report showing the number of medical report of each physician has remaining incomplete in excess of thirty (30) days after notification. The Medical Advisory Committee will utilize this report and other relevant delinquent clinical notes reports in evaluating practitioner performance regarding timeliness of notes completion and in considering disciplinary action, if appropriate.

Each Head of Clinical Department, may administratively reassign the clinical duties of Medical Practitioners to enable those Practitioners with delinquent medical records, as defined by the Medical Record Committee, to complete such delinquent records.

Each Head of Clinical Department may also administratively reassign the clinical duties of Medical Practitioners to enable those Practitioners who have not demonstrated compliance with OSHA, communicable disease or other Hospital safety requirements in order to demonstrate such compliance. Such administrative reassignment shall not be considered disciplinary action against Medical Practitioners. However, repeated administrative reassignments which have the effect of being detrimental to the operations of the Hospital may subject a Medical Practitioner to disciplinary action.

C19. Medical Records/Reports Delinquency Policy - The Medical Records/Reports Delinquency Policy will determine the course of action for staff discipline.

C20. Alterations/Corrections of Medical Records - Late entries/additions to medical records shall comply with current PL-033 Medical Record Policy.

D. GENERAL CONDUCT OF CARE

D1. Doctor ‘s Orders

a. All orders for treatment shall be in writing and written by attending practitioner

b. Verbal communication of treatment and test results shall be permitted for urgent situations only, in which immediate written or electronic communication is not feasible.

Orders dictated over the telephone shall be signed by the appropriate authorized person according to PL-029 Verbal Communication Policy, whom dictated and indicating the name of the Practitioner who gave the
order. After transcription, the details of the order will be repeated out loud by the person receiving the order and confirmed by the person giving the order. The Practitioner giving the order shall authenticate such verbal orders as soon as possible and not more than twenty four (24) hours after such order.

c. Legibility of Orders - The practitioner’s orders must be written clearly, legibly and completely, dated and timed all the orders. Orders which are illegible or improperly written will not be carried out until rewritten and understood by the nurse.

d. In the case of irreversible illness of a patient in which death is imminent where emergency procedures to treat cardiac or pulmonary arrest may not be desired, the practitioner, after appropriate consultation with the patient and/or family and after adequate documentation in the record, shall write the order PL-041 UMMC Do Not Resuscitate Advance Directive Policy.

D2. Medication Orders

All medications administered to patients shall be those approved by Hospital Drug and Therapeutic Committee as listed in the latest edition of hospital drugs list with the exception of drugs for approved clinical investigation. These shall be used in accordance with the Medical Ethic Committee requirements and all regulations of the National Pharmaceutical Bureau. The practitioner must write a complete medication order consisting of drug name, dosage, route and frequency, duration, signature and name/official stamp of the prescriber. Orders which do not contain all these elements cannot be carried out until completed by the practitioner and will consider as prescription error.

Medication Safety and Drug & Therapeutics Committees will develops and maintains surveillance over medication safety, utilization policies and practices including
- establishing systems and education programs to prevent medication errors;
- monitors all reported drug reactions and drug errors in order to define system failures; and
- provides a quarterly report to the Risk Management Committee, consisting of statistical data involving drug reactions and drug errors, their probable causes and actions taken to improve systems and follow-up evaluation to assure the process for improvement is maintained.

a. Medication Administration

Intravenous Medication administration shall comply to Hospital procedure for IV Medication administration. Certain medications may be administered only by a physician or under his/her direct supervision when given by the I.V. bolus method.
b. Medication From Other Sources
   For the safety of the patient no medications acquired by a practitioner from sources other than the hospital for use in patient care in the hospital shall be administered. Should there be needed exceptions, due to non-availability, the practitioner shall contact the Head of Pharmacy or person in charge.

c. Surrender of Medications
   Upon admission, all patients will be asked to surrender medications brought from home to be returned to a family member or secured in the hospital pharmacy and returned to the patient at discharge. Only medication prescribed by the attending physician will be given to the patient during administration. Medication ordered by the attending physician will only be supplied by the Hospital Pharmacy and administered by qualified personnel unless otherwise defined by Hospital policies and procedures. A list of exceptions to this requirement will be determined by the Pharmacy and Therapeutics Committee and will be available in the Pharmacy Portal Website.

d. Blanket standing orders for patient care will not be accepted.

D3. Sedation
   Procedures involving sedation analgesia for patients for procedures given in any location in the hospital, shall be in accordance with current sedation policies.

D4. Ordering Blood
   Blood which has been cross-matched and is being held for a patient will be held for 48 hours at which time the order for the blood will be canceled unless reordered for another 48 hours and management of blood transfusion shall follow blood transfusion guidelines.

D5. Pre-printed Orders/Instruction Sheets
   Preprinted orders and/or instruction sheets shall be reviewed by all affected departments and revised as necessary and instituted only after approval of the Medical Advisory Committee. Such preprinted orders and/or instruction sheets shall be reviewed and revised as necessary. All preprinted orders and/or instruction sheets must be signed and dated by the responsible practitioner when utilized, as required for all orders for treatment.
D6. Consultation Requirements

Any qualified practitioner with clinical privileges in this Hospital can be called for consultation within his/her area of expertise. Primary physicians, or consultants, or their designees shall respond in a timely manner with urgent calls to be returned within five (5) minutes and routine calls within a reasonable time, so that patient care is not delayed. If an urgent request, the requesting physician shall notify the consultant. Verbal informed consent for elective blood transfusion shall be taken from patient/surrogate and documented in the medical records. Patient/surrogate shall be given patient information sheet on blood transfusion.

D7. Doubt or Question About Patient Care/Incident Reporting

In the event that professional hospital staff has any concerns regarding the quality of care provided to a patient by any health care provider including physicians and hospital staff, the Medical staff may contact the following personnel in order to get resolution to the concern:

• Head of Department or immediate supervisor – if unavailable or if response is unsatisfactory, contact next:
• Quality officer or Risk Management officer who will contact the following persons if additional assistance is needed:
  1. Head of Quality
  2. Deputy Director Professional
  3. Director

The report shall be given via online incident reporting system. All the information is considered as confidential and confidentiality measures shall be maintained.

D8. Patient and Family Rights

The Medical Staff acknowledges the following patient and family rights and will comply with Hospital policy for preservation of these rights:

a. Access to Care:
   i) Individuals shall be given an access to treatments and care that are available or medically indicated, regardless of race, national origin, religion, disability, age or source of payment for care.

b. Pain: To appropriate assessment and management of pain throughout the continuum of care.

c. Religious support counseling: Staff will make arrangements if so indicated when asked upon admission or requested at any time throughout the patient’s hospitalization.
e. Ethics: To participate in the resolution of ethical decisions, including conflict resolution, withholding resuscitative measures or withdrawal of life support;

f. Organ Donation: To declare his/her wishes regarding organ donation. The hospital has policies and procedures for procuring and donating organs and other tissues.

g. Patient Complaint/Grievance Procedure: To be given information upon admission regarding the process, contacts persons and times for which to make a complaint/grievance and to have access to the direct contact line of the person in charge

h. Privacy and Confidentiality: The patient has the right, within the law to personal and informational privacy, including the right to:
   i) Refuse to talk with or see anyone not officially connected with the Hospital, including visitors or people officially connected with the Hospital but not directly involved in the patient's care;
   ii) Wear appropriate personal clothing and religious or other symbolic items as long as they do not interfere with the diagnostic procedures or treatment;
   iii) Be interviewed and examined in surroundings designed to ensure reasonable audiovisual privacy
   iv) Expect that any discussion or consultation involving his/her case will be conducted discreetly;
   v) Expect all communications and other records pertaining to his/her care, including the source of payment for treatment, to be treated as confidential;
   vi) Request a transfer to another room if another patient or visitors in that room is unreasonably disturbing the patient.
   vii) To know when his/her admission has been flagged as confidential, and once an admission has been flagged as confidential, disclosure of the patient’s room number will be prohibited to visitors. No telephone calls or deliveries will be sent without patient permission.
   viii). Personal Safety: To expect reasonable personal safety so far as the Hospital practices and environment are concerned. The patient has the right to be free from all forms of abuse or harassment and the right to Security assistance when that need arises or information is given to the facility. Community resources and other protective services will be made available to the patient or referral made when needed.
ix). Identity: To know the identify and professional status of individuals providing service to him/her and to know which physician or practitioner is primarily responsible for his/her care. Participation by the patient in clinical training programs or in the gathering of data for research purposes is voluntary.

x). Information: To a prompt and reasonable response to questions and requests. A patient has the right to know what patient support services are available in the Hospital and the right to obtain from the practitioner responsible for coordinating his/her care complete and current information concerning his/her diagnosis (to the degree known), treatment and any known prognosis and outcomes of care including unanticipated outcomes. The patient has a right to get second opinion from other practitioners if necessary. Families may also be informed with permission of the patient or when the patient is unable to answer for themselves. This information should be communicated in terms the patient can reasonably be expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to a legally authorized individual. The patient has the right to see his/her medical record in accordance with PL-033 Medical Record Policy.

xi). Communication: To access people outside the hospital by means of visitors and by verbal and written communication. When the patient does not speak or understand the predominate language of the community, he/she should have access to an interpreter. This is particularly true where language barriers are a continuing problem. When the hearing impaired requires a sign language interpreter, one will be provided.

xii). Consent: To participate in decisions involving his/her healthcare. To the degree possible, this should be based on a clear, concise explanation of his/her condition and of all proposed technical procedures, including the possibilities of any risk of mortality or serious side effects, problems related to recuperation and probability of success. The patient should not be subject to any procedure without his/her voluntary, competent and understanding consent. When the patient is not competent, a legal guardian or next of kin may consent. Where medically significant alternatives for care or treatment exist, the patient shall be so informed. The patient has the right to know who is responsible for authorizing and performing the procedure or treatment. The patient shall have full disclosure related to research and the patient shall be informed if the Hospital proposed to engage in or perform human experimentation or other research/educational projects affecting his/her care or treatment. The patient has the right to refuse to participate in such treatment.
Consultation: To consult, at his/her own request and expense, with a private specialist.

i. Refusal of Treatment: To refuse treatment to the extent permitted by law. When refusal of treatment by the patient or his/her legally authorized representative prevents the provision of appropriate care in accordance with ethical and professional standards, the patient has to sign “Refusal/Against Medical Advice” form.

j. Transfer and Continuity of Care: A patient may not be transferred to another facility unless he/she has received a complete explanation of the need for transfer and the alternatives to such a transfer, and unless the transfer is acceptable to the other facility. The patient has the right to be informed by the responsible practitioner or his/her delegate of any continuing healthcare requirements following discharge from the Hospital.

k. Hospital Charges: Regardless of the source of payment for his/her care, the patient has the right to request and receive an itemized total bill for hospital services. The patient has the right to receive a reasonable estimate of charges for medical care before treatment.

l. Hospital Rules and Regulations: To be informed of the Hospital rules and regulations applicable to his/her conduct as a patient. Patients are entitled to information about the Hospital’s mechanism for the initiation, review and resolution of patient complaints.

m. Complaints: To complain to the ward manager, staff member, or the administrative officer/Public Relation officer in any patient care area regarding the quality of care received. Presentation of a complaint does not serve to compromise a patient’s future access to care. Patients are entitled to resolution of complaints that are presented when possible. The patient will be involved in resolving dilemmas about care. Formal complaint in writing or verbal complaint not promptly resolved by staff and requiring administrative intervention will be considered official grievances and will be investigated by appropriate staff. A written response or a verbal meeting with the patient will be provided within 30 days.

n. Minor’s Rights/Responsibilities: If the patient is a neonate, child, or adolescent, the patient has the right to have a parent or guardian involved in the assessment, treatment and continuity of care. Conflicts that arise concerning the care of the patient would be resolved according to hospital policies and procedures.
Advance Directives: To receive written information about advanced directives and healthcare decision-making options according to hospital policy

o. Free From Restraint: To be free from restraints unless medically necessary. Restraints shall not be used as a means of coercion, discipline, convenience or retaliation by staff.

D9. Autopsy

Autopsy shall only been carried out by credentialed practitioner/pathologies. No autopsy shall be conducted without consent from relative except for Medico-legal case or upon receiving police order. Management of Medico-legal death shall be according to the hospital policy

E. SURGICAL AND INVASIVE PROCEDURE CARE

E1. Requirements Prior to Surgery - Except in emergencies in which delay may be life threatening or will severely or permanently compromise the patient’s health, a history and physical examination, the pre-operative diagnosis, appropriate consents, required laboratory and radiology reports and consultations when requested, must be recorded on the patient's medical record prior to any surgical or invasive procedure. In the case of an emergency, where any or all of the above entries have not been made in the medical record, the operating surgeon shall state in writing that a delay would be detrimental to the patient (and shall make a comprehensive note in the medical record indicating the patient's condition prior to induction of anesthesia and the start of surgery). When history and physical examinations are not recorded before the time stated for operation, the operation shall be cancelled, unless attending surgeon states in writing that such delay would be detrimental to the patient. The reasons and investigation report for failure to record history and physical examination will be submitted to the Director by the head of Unit within 24 hours or surgical operation having been carried out under such circumstances

a. In the case of patients undergoing invasive procedures other than in the operating room, a pre-procedure assessment would minimally include, but not be limited to, pertinent historical information such as patient's chief complaint or diagnosis, indication for the invasive procedure, allergies and current medications. Pertinent physical findings would be noted, the assessment would be appropriate for the procedure performed, and the patient's informed consent shall be documented in the chart.

b. No surgical operations will be carried out without the written consent of patients or of parent/guardian in case of minors.

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No. Kajisemula R00
**E2. Timeliness of Physician Presence in the Operating Room** - Surgeons shall be in the operating room and ready to commence surgery at the time scheduled. If a surgeon is repeatedly or flagrantly late, he may have his/her privilege to schedule first case surgery suspended or may be referred to the Advisory Committee for action. The surgical team shall comply with time-out verification policy and procedure.

**E3. Anesthesiologist Responsibilities** - The anesthesiologist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up of the patient's condition. The anesthesia record should also include thorough documentation of times and amounts of all medications given.

a. The anesthesiologist is responsible for writing a pre-anesthetic note in the medical record prior to the procedure and before pre-operative medication has been administered. This note shall indicate a choice of anesthesia and the surgical or obstetrical procedure anticipated.

b. The anesthesiologist is responsible for writing a post-anesthetic note after the patient has completed post-anesthesia recovery care to include at least a description of the presence or absence of anesthesia-related complications.

**E4. Trainee** - A trainee who is classified in a supervisory status for specified surgery privileges must have his/her supervisor or qualified assistant present during the surgery for these specified surgery procedures. The criteria and the complexity of the surgery required the supervisor/specialist physically available during the surgery shall be decided and will be the responsibility of the individual Head of Department.

**E5. Dispositions of Specimens/Tissues** - Unless otherwise specified by hospital policy, all tissues removed at the operation shall ordinarily be sent to the hospital pathologist who shall make such examination as he may consider necessary to arrive at a tissue diagnosis. His/her authenticated report shall be made a part of the patient's medical record. Exceptions to sending specimens removed during a surgical procedure to the laboratory should be made only when the quality of care has not been compromised by the exception, when another suitable means of verification of the removal has been routinely employed, and where there is an authenticated operative or other official report that documents the removal. The limited categories of specimens documented in the Surgical Specimens/Tissue Exemption List may be exempted from the requirement to be examined by a pathologist. The specimen/tissue disposition will be managed by Pathology Department unless the request make by the patient to have back certain organ or limb before the surgery.
Amendments

These *Rules and Regulations* may be amended by a majority vote of the members of the MAC present and voting at any meeting of that Committee where a quorum exists, provided that written recommendations concerning the proposed amendments were received and reviewed by the members of the Committee prior to the meeting. No such amendment will be effective unless and until it is adopted by the Board of Management.

These *Rules and Regulations* may also be amended by the Board of Management on its own motion provided that any such amendment is first submitted to the MAC for review and comment at least fourteen (14) days prior to any final action by the Board of Management on such amendment.